Mental Health Tribunal

# 2015 / **2016** Annual Report

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19 August 2016

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 annual report of its operations for the period 1 July 2015 to 30 June 2016.

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

In the years leading up to the enactment of the *Mental Health Act 2014* (the Act), there was an extraordinary level of comprehensive consultation, over the course of which aspirations were articulated and, in some instances, compromises reached. When the Act commenced, all those impacted by it grappled with the new legal framework and with changing roles, responsibilities and practices. Now we are at a critical juncture where the Act is no longer 'the new Act' and previously unfamiliar processes are now routine. Yet the cultural change envisaged by the Act is still in its infancy. As we become more comfortable operating within the Act's framework, our challenge is to retain a focus on continuing to develop our practices and decision making to ensure that the principles of the Act resonate as the lived experience of consumers and those who care for them.

This is as significant a challenge for the Mental Health Tribunal (the Tribunal) as it is for any other entity with responsibilities and functions under the Act – and it is a challenge that raises particular, and often testing, issues for the Tribunal. The Tribunal's role is complex, not only because mental health is complex, but because the performance of the Tribunal's functions and decision making responsibilities under the Act require a holistic consideration of the legal, policy and treatment dimensions of mental health.

The complexity that arises from this can be difficult to navigate and the Tribunal has responded to this complex and demanding environment by developing a Continuous Improvement Performance Model (CIPM) for members. CIPM grew from the recognition that we needed an additional suite of resources to assist members to perform their roles in accordance with a clear set of standards, with those standards being grounded in the principles of the Act. These resources include a broad competency framework, guidance on working as part of a multidisciplinary team so as to maximise the rich opportunities afforded by our structure and the diverse background and experience of our members, and procedures for making practice reflection part of both our day-to-day work and ongoing professional development. Over the coming 12 months we will be taking this work further, with a focus on developing performance feedback processes to ensure we all meet these standards and expectations.

CIPM complements and seeks to embed the approach to the conduct of hearings that is articulated in the *Guide to Solution-Focused Hearings in the Mental Health Tribunal*. This guide was developed in the lead-up to the commencement of the Act. It has always been acknowledged as a starting point from which we would continue to refine and develop the Tribunal's approach. I flagged in last year's annual report that work was being undertaken to expand the guide and I am pleased to confirm that, after comprehensive consultation, an additional chapter to the guide has been finalised. This new chapter examines the particular needs of young people who have hearings with the Tribunal, and includes a range of strategies that can be used to enhance their experience of hearings. Similar work examining the needs of older people has also progressed significantly.

Engagement with consumers and carers continues to be a primary focus of the Tribunal, with the Tribunal Advisory Group (comprising four consumer and four carer representatives) being the core driver of this strategy. Quite rightly, the members of the Tribunal Advisory Group encourage us to pursue an ambitious range of initiatives intended to promote the participation of consumers and carers. At the same time, they have been very understanding of the fact that our capacity does not enable us to do everything at once, and they are invaluable partners in the development and delivery of those initiatives that are underway. Over the course of 2015/16, key initiatives have included the development of a consumer and carer experience of hearings survey (scheduled to be piloted in late 2016); the redevelopment of key information products and their translation to community languages; and planning for the Tribunal's second consumer and carer forum (that will take place in November).

The ability of the Tribunal to undertake developmental and forward-looking work is dependent on the effective operation of its core function – the conduct of hearings. This year, the Tribunal continued to conduct hearings in accordance with the strict timelines set down in the Act, including the handling of a significant number of urgent applications. This represents a continuation of the high standard set in our first year of operation, despite the challenge of an 18% increase in the number of hearings listed and a 13% increase in the number of hearings conducted. Alongside managing this increase in hearings, the Tribunal continued to explore and implement

improvements to our hearing schedule. Twice each year, the Registry reviews arrangements for the 57 venues where hearings are conducted to ensure we are providing sufficient service, and to explore whether potential changes might promote access to legal representation or reduce the proportion of hearings conducted by videoconference. This year, we were also able to resume conducting some in-person hearings at Warrnambool and Wangaratta, visiting both venues every three months.

The Tribunal has also maintained its commitment to transparency about its decision making. Every quarter, we publish comprehensive statistics relating to the number of matters being handled by the Tribunal and the profile of determinations. This statistical data is complemented by the publication of the majority of the Tribunal's written statements of reasons that explain our approach to the interpretation and application of the Act. These reasons capture the dialogue that occurs in hearings between patients, carers, advocates, mental health clinicians and the Tribunal about how the Act should be applied in the circumstances of the individual patient. In addition to meeting a person's right to know how and why a decision was made (which might also be needed for a review process), the broader publication of reasons contributes to the ongoing systemic assessment of how the Act is playing out in practice.

It is only because the Tribunal has an exceptionally committed and hard-working group of both staff and members that it is able to undertake the work that is detailed in this report.

Things don't always go smoothly; infrastructure sometimes doesn't operate as we would like it to; and there are significant personal, professional and practical challenges in dealing with the complex, often emotionally charged issues that come before the Tribunal. Nonetheless, our staff and members are resolute in their professionalism, good will and commitment to getting things done, and in working to the highest standard possible. I thank everyone for their efforts over the past 12 months.

We are now entering the Act's third year of operation and interest in the evaluation of its impact and effect is beginning to grow across the sector. The Tribunal is eager to be part of a broad evaluation process and to contribute as fully as possible. We want to confirm what has worked and identify the gaps and unmet expectations.

To acknowledge the profound impact of compulsory treatment and the decisions of the Tribunal on the lives of consumers and carers is a statement of the glaringly obvious. But we need to remind ourselves of this constantly and we must test our processes and practices to confirm whether our approach translates the principles of the Act from words in a statute to the actual experience of consumers and carers.

**Matthew Carroll**
President

Engagement with consumers and carers continues to be a primary focus of the Tribunal, with the Tribunal Advisory Group being the core driver of this strategy.

# 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:<br>• Accessible<br>• Collaborative<br>• Responsive and solution focused<br>• Respectful of diversity and individual dignity<br>• Accountable and professional<br>• Committed to learning and development. |
| **Our goals** | **1 Participation –** maximising opportunities for consumer and carer participation<br>**2 Excellence in tribunal practice –** embedding best practice in all aspects of our operation<br>**3 Building excellence in mental health law –** promoting transparency in decision making and contributing to the implementation and development of the Mental Health Act. |

## Our obligations under the Charter of Human Rights and Responsibilities

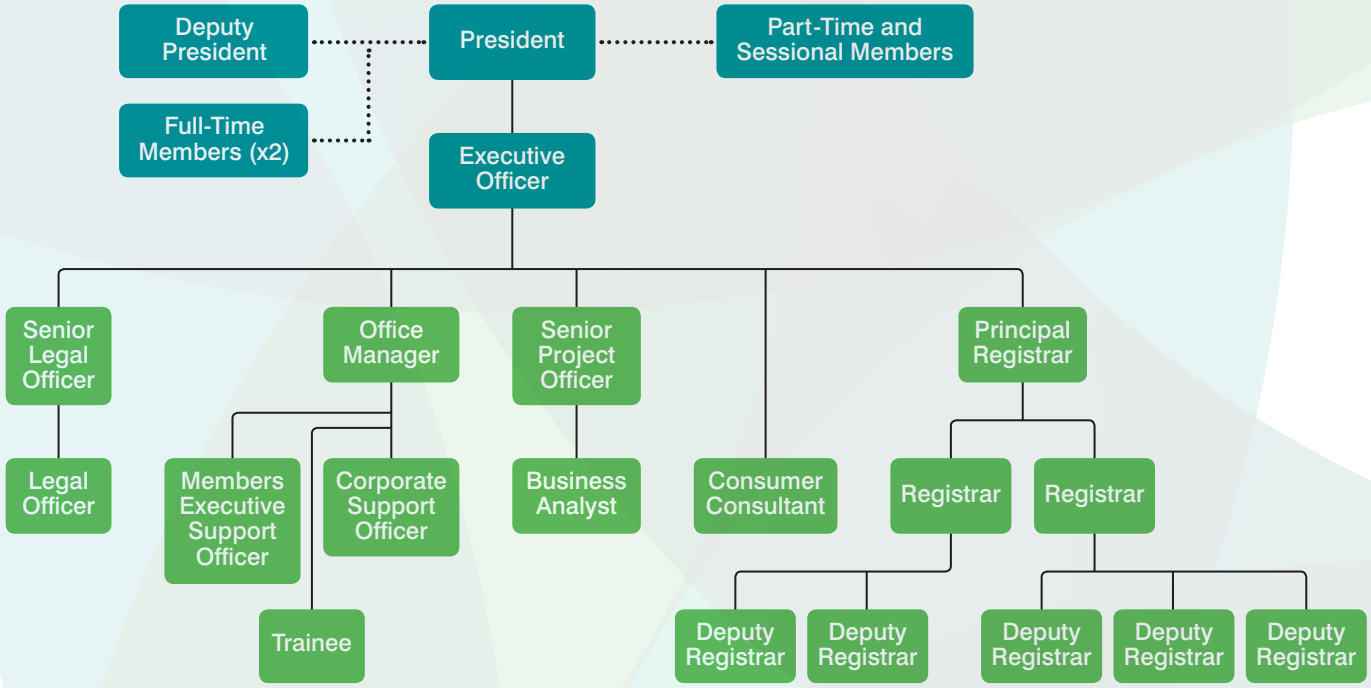
As a public authority under the Victorian *Charter of Human Rights and Responsibilities* (the Charter), the Tribunal must adhere to a number of human rights obligations. The Charter requires the Tribunal to give proper consideration to all relevant human rights when making decisions; it must also act 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.

## Membership changes during 2015/16

This year the Tribunal farewelled a number of members, all of whom made significant contributions to the work of both the Tribunal and the former Mental Health Review Board over a number of years. Departing Legal Members were Graeme Bailey (after 27 years of continuous membership), Joan Dwyer and Dominique Saunders (a sessional member since 2003 and the Tribunal's first Deputy President). Dr Tom Peyton, Dr Jan Steele and Prof Dennis Velakoulis (Psychiatrist Members) and Margaret Fowler (Community Member) did not seek reappointment when their terms concluded in February.

The Tribunal also welcomed a number of new members following the completion of an appointment round in February. Darryl Annett, Jennifer Ellis, Tamara Hamilton-Noy, Anthony Lupton and Alison Murphy joined as Legal Members, and our new Community Members are Professor Margaret Hamilton, Sarah McWilliams and Aroon Naidoo. Nine new psychiatrist members were appointed: Doctors Mark Arber, Robert Chazan, Joanne Fitz-Gerald, David Hickingbotham, Ahmed Mashhood, Amanda Rynie, Sudeep Saraf, Rosemary Schwarz and Sally Wilkins. Dr Sandra Neate and Dr Kaye Ferguson joined as Registered Medical Members.

***Figure 1:*** *Mental Health Tribunal Organisational Chart*



# Part 1 Functions, procedures and operations 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 electro-convulsive treatment on a patient who does not have capacity to give informed consent;
v. an application to perform electro-convulsive 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.

### 1.1.2 Electroconvulsive Treatment (ECT)

The Tribunal will determine whether 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)

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

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

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

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

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

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

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

## 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 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 57 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.

Work is continuing 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 7,000 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.

More detailed information about how the Tribunal's case management procedures are applied is included in Part Three.

### 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.

### 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.

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

## 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.

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

- a *Guide to Procedural Fairness in the Mental Health Tribunal*, which details strategies specific to this jurisdiction that members can use to ensure hearings are conducted in accordance with the rules of 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
- guidance materials on the interpretation and application of the *Mental Health Act 2014*.

Alongside these resources, in order to lay the foundation for and promote ongoing improvement and cultural change, over the past 18 months the entire membership has contributed to the development of an over-arching framework and companion resources to guide how we work both individually, and as part of a multi-disciplinary team. This framework and set of resources is our Continuous Improvement Performance Model (CIPM) and provides a coherent and consistent guide to all members whether they are new to the role or experienced.

### 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.

### 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.

### 1.3.5 Review by VCAT

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

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

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

### 1.3.6 Statements of reasons

Under s198, 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 the current year, the Tribunal received 232 requests for a statement of reasons. The Tribunal initiated 11 further statements of reasons.

**Publication of Statements of Reasons**

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

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

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

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

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.

### 1.3.7 Rules and Practice Notes

Practice notes deal mainly with 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 these hearings. The Tribunal commenced operation in July 2014 with an initial set of Rules governing essential aspects of its operation, accompanied by six practice notes.

This year, the Tribunal finalised Practice Note 7 *Observers at Mental Health Tribunal Hearings*. Tribunal hearings are closed to the public, given the private and sensitive nature of the matters being discussed; however, frequent requests are made for individuals to observe hearings. The most common reason for these requests is related to the training of doctors and other clinical staff. The practice note sets down a pre-hearing process for the making of requests to observe and identifies the key considerations the Tribunal will take into account when deciding whether to grant such a request, the central consideration being the views of the person the hearing concerns.

A significant amount of work was also undertaken to develop a practice note covering access to information prior to Tribunal hearings, including the process to be followed where a psychiatrist is applying to withhold documents. In the vast majority of matters, access to information is relatively straightforward; however, it can be the cause of significant confusion when complex scenarios arise. The Tribunal is in the last phase of consultation about its practices in relation to pre-hearing access to information, after which the Rules Committee will consider the feedback provided in order to finalise and release this practice note.

All practice notes are available on the Tribunal's website.

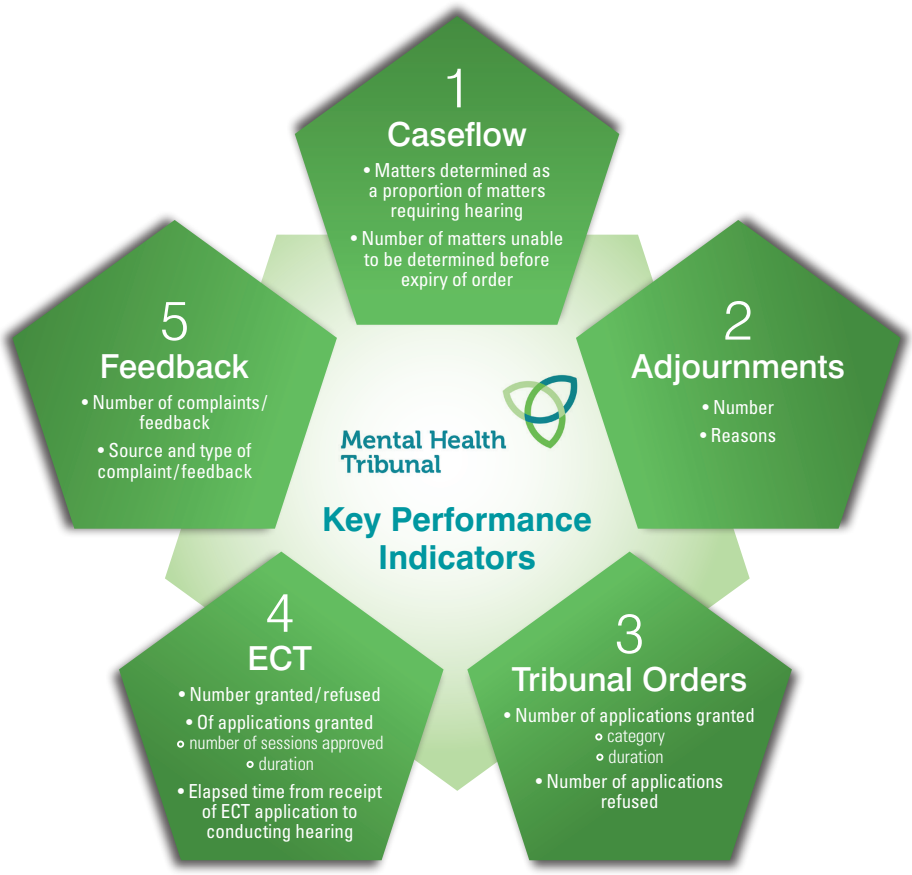
## 1.4 Administrative operations

### 1.4.1 Key Performance Indicators

The Tribunal has established Key Performance Indicators (KPIs) and publishes quarterly reports against these KPIs on the Tribunal's website.

The Tribunal Advisory Group reviewed the Tribunal's KPIs in December 2015 and recommended that the quarterly reports detail attendance at hearings by patients, family members, carers and nominated persons. This information has been included in reports since the beginning of 2016.

***Figure 2:*** *Mental Health Tribunal KPIs*




### 1.4.2 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.

### 1.4.3 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 or phone or by completing an online form. The Tribunal's quarterly Key Performance Indicator reports (see Section 1.4.1) provide a summary of issues raised in complaints or feedback received by the Tribunal.

The establishment of the Tribunal's 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.

### 1.4.4 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 continues to develop short, medium and long-term strategies to address these issues. As the CMS is closely integrated with the statewide mental health database and systems used by mental health services, the Tribunal will continue to work with the Department of Health and Human Services on the implementation of solutions.

### 1.4.5 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.

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.

#### 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 (MHAG)
- Mental Health Complaints Commissioner
- Office of the Chief Psychiatrist
- TANDEM
- VMIAC
- Vicserv.

### 1.4.6 Educational activities

The Tribunal undertakes 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, and full and part time members. The Tribunal's registry staff also meet with administrative staff at designated mental health services to explain the Tribunal's processes for managing hearings, and to explore how services and the Tribunal can work together most effectively.

# Part 2 | Hearing statistics for 2015/16

## Key statistics at a glance*

| | |
|---|---|
| Hearings listed ** | **12 211** |
| Hearings conducted | **7 478** |
| Hearings with determination made | 6 886 |
| Hearings adjourned | 592 |
| Treatment Orders made | **5 605** |
| Temporary Treatment Orders / Treatment Orders revoked | **358** |
| ECT Orders made | **620** |
| ECT applications refused | **86** |
| NMI hearings conducted | **2** |
| Patients attending hearing | **3 993** |
| Family attended hearing | **1 081** |
| Carers attended hearing | **360** |
| Nominated persons attended hearing | **308** |
| Patients with legal representation at hearing | **1 046** |
| Interpreters at hearing | **236** |
| Statements of Reasons requested | **243** |
| Applications to VCAT | **20** |

* *The figures in sections 2.1 to 2.12 represent determinations at substantive hearings and exclude hearings that were adjourned or where no determination was made.*

** *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.*
*Calculations from 2014/15 may have been revised from figures published in the 2014/15 Annual Report to apply an improved reporting methodology.*

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

A case type can be defined as the 'trigger' for a hearing. For example, an application for 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 Outcomes of hearings regarding Treatment Orders

In 2015/16, the Tribunal made a total of 5605 Treatment Orders (TOs) and revoked 358 Temporary Treatment Orders (TTOs). There were a small number of matters where the Tribunal found it did not have jurisdiction to conduct a hearing (12) and 64 applications were struck out. The most common reason for a strike out is where a patient has made an application for revocation and fails to appear at the hearing. When an application is struck out the underlying Treatment Order or Temporary Treatment Order is not affected and continues to operate, furthermore, a patient is able to make a further application if they wish to do so.

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

***Table 1:*** *Determinations regarding Treatment Orders*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Community Treatment Orders made | **3120** | **52%** | **+21%** | 2588 | 48% |
| Inpatient Treatment Orders made | **2485** | **42%** | **+7%** | 2324 | 44% |
| Temporary Treatment Orders / Treatment Orders revoked | **358** | **6%** | **-14%** | 417 | 8% |
| Total Orders made or revoked | **5963** | **100%** | **+12%** | 5329 | 100% |

***Figure 3:*** *Determinations regarding Treatment Orders*

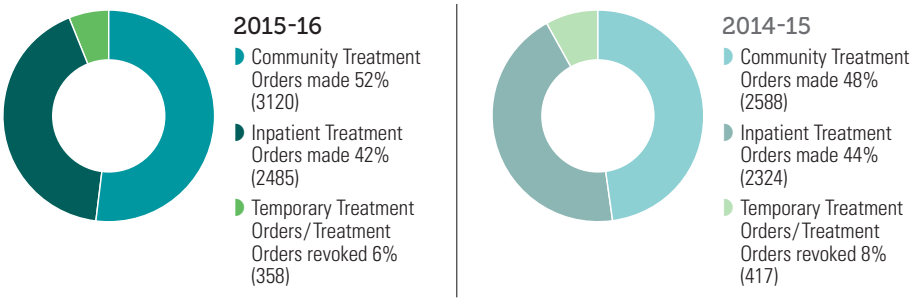


*Table 2: Duration of Community Treatment Orders made*

| | 2015–16 No. | % | % variation of numbers from 2014–15 | 2014–15 No. | % |
|---|---|---|---|---|---|
| 1–13 weeks | 477 | 15% | +18% | 403 | 16% |
| 14–26 weeks | 1192 | 38% | +29% | 923 | 36% |
| 27–39 weeks | 51 | 2% | -18% | 62 | 2% |
| 40–52 weeks | 1400 | 45% | +17% | 1200 | 46% |
| Total | 3120 | 100% | +21% | 2588 | 100% |

*Figure 4: Duration of Community Treatment Orders made*

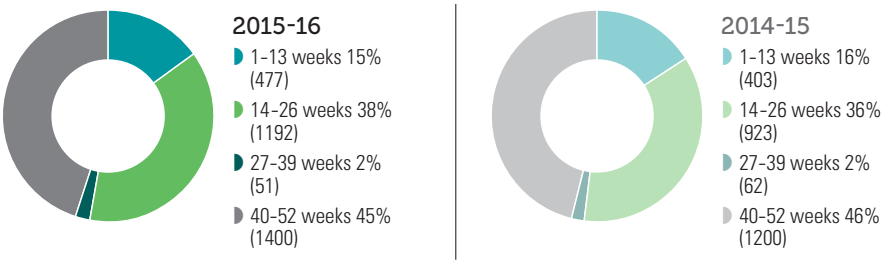
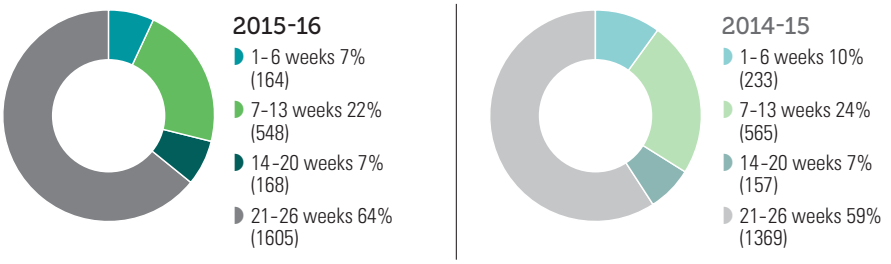



*Table 3: Duration of Inpatient Treatment Orders made*

| | 2015–16 No. | % | % variation of numbers from 2014–15 | 2014–15 No. | % |
|---|---|---|---|---|---|
| 1–6 weeks | 164 | 7% | -30% | 233 | 10% |
| 7–13 weeks | 548 | 22% | -3% | 565 | 24% |
| 14–20 weeks | 168 | 7% | +7% | 157 | 7% |
| 21–26 weeks | 1605 | 64% | +17% | 1369 | 59% |
| Total | 2485 | 100% | +7% | 2324 | 100% |

*Figure 5: Duration of Inpatient Treatment Orders made*



## 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 following graphs break down these figures by initiating case type – that is, the 'event' that triggered the requirement for the hearing.

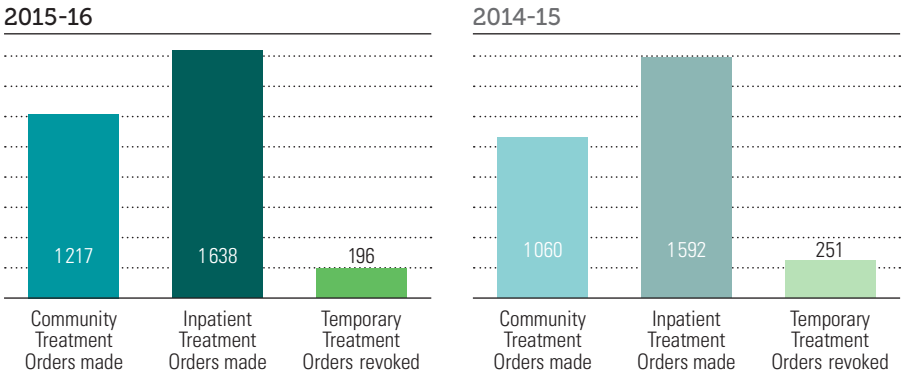
### 28 day hearings

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 graphs below, the Tribunal can either make a Treatment Order or revoke the Temporary Treatment Order.

*Table 4: Outcomes of 28 day hearings*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Community Treatment Orders made | 1217 | 40% | +15% | 1060 | 36% |
| Inpatient Treatment Orders made | 1638 | 54% | +3% | 1592 | 55% |
| Temporary Treatment Orders revoked | 196 | 6% | -22% | 251 | 9% |
| Total Orders made or revoked | 3051 | 100% | +5% | 2903 | 100% |

*Figure 6: 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 under s5 were as follows (in descending order):

- Immediate treatment is reasonably available by less restrictive means (i.e. s5(d) did not apply).
- Immediate treatment will not be provided (i.e. s5(c) 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).

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.

The Tribunal may form 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 fourteen 28 day hearings.

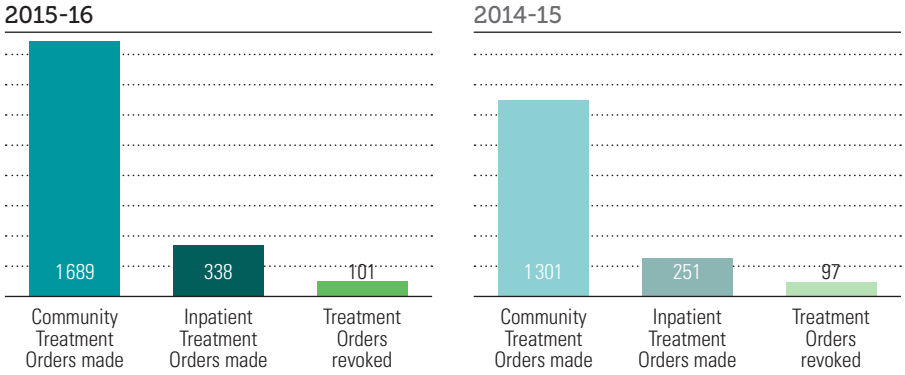
### Application for a Treatment Order by the authorised psychiatrist

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.

*Table 5: Outcomes of hearings where the authorised psychiatrist has applied for a further Treatment Order*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Community Treatment Orders made | 1689 | 79% | +30% | 1301 | 79% |
| Inpatient Treatment Orders made | 338 | 16% | +35% | 251 | 15% |
| Treatment Orders revoked | 101 | 5% | +4% | 97 | 6% |
| Total Treatment Orders made or revoked | 2128 | 100% | +29% | 1649 | 100% |

*Figure 7: 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 Treatment Order with respect to applications by the authorised psychiatrist 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).

In relation to four 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.

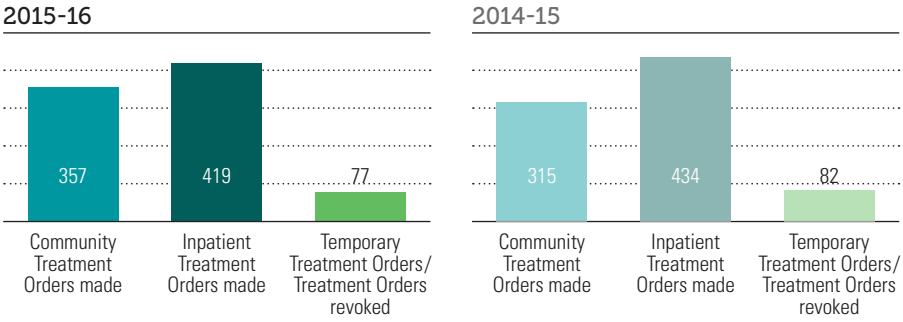
### Application for revocation by or on behalf of a patient

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.

*Table 6: Outcomes of applications for revocation of an Order*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Community Treatment Orders made | 357 | 42% | +13% | 315 | 38% |
| Inpatient Treatment Orders made | 419 | 49% | -3% | 434 | 52% |
| Temporary Treatment Orders / Treatment Orders revoked | 77 | 9% | -6% | 82 | 10% |
| Total Orders made or revoked | 853 | 100% | +3% | 831 | 100% |

*Figure 8: Outcomes of applications for revocation of an Order*




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 previously regarding applications for a further Treatment Order by the authorised psychiatrist.

In relation to two 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.

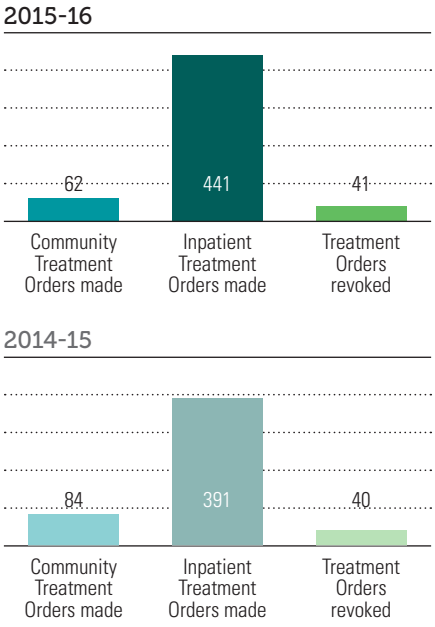
### Variation hearings

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.

*Table 7: Outcomes of variation hearings*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Community Treatment Orders made | 62 | 11% | -26% | 84 | 16% |
| Inpatient Treatment Orders made | 441 | 81% | +13% | 391 | 76% |
| Treatment Orders revoked | 41 | 8% | +2% | 40 | 8% |
| Total Treatment Orders made or revoked | 544 | 100% | +6% | 515 | 100% |

*Figure 9: 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 five 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.

# Case study

## Illustration 1
### Examining capacity in ECT applications

In ECT applications, the first question the Tribunal must consider is whether the patient has the capacity to give informed consent. In considering this criterion, the Tribunal must look at four separate domains: does the patient have the ability to understand, remember, and use or weigh information that is relevant to the decision, and are they able to communicate their decision. Consideration of these matters is very dependent upon the circumstances of the individual patient. Each decision of the Tribunal can provide guidance but it is fundamentally a decision about the individual.

In *YBI* [2016] VMHT 26, YBI's mental state had fluctuated throughout his admission – he had episodes of agitation and aggression, responding to internal stimuli, but at other times he had been more settled and able to have periods of leave from hospital with his family. The treating team submitted that YBI did not have capacity to given informed consent to ECT. When asked about the basis of this conclusion, the presenting doctor confirmed that he had not himself had any specific discussions about ECT with YBI but that, based on YBI's symptoms, he would not have had capacity if that conversation had taken place. YBI's father stated YBI could engage in a conversation about ECT if he was given enough time and in a supportive environment with his parents. The lack of appropriate discussions with YBI concerning ECT meant there was an insufficient basis for the Tribunal to be persuaded that the patient lacked capacity to give informed consent. Therefore, the Tribunal refused to grant the application.

In *QSC* [2016] VMHT 4, the treating team stated that QSC had been very anxious in discussing ECT as a treatment option and had not been able to discuss the precise nature of the ECT that was proposed (the team proposed to perform unilateral ECT, which was different from the ECT that QSC had received in the past) and he could not appreciate the recommendation of the treating team – that it was hoped ECT would reduce his prescribed medication and hasten his discharge from hospital. QSC was calm during the hearing and was able to follow and understand the submissions of the treating team and his legal representative, as well as his parents' concerns. When questioned by the Tribunal, QSC was able to explain how the proposed ECT was to be conducted, and the benefits and risks associated with the procedure. After hearing the treating team's evidence during the hearing, QSC said he now understood the proposed ECT and had he and his family been provided with comprehensive written material about the proposed ECT, he would have been able to work more collaboratively with the treating team. The Tribunal refused to grant the application as QSC had capacity to give informed consent. QSC said he would seriously consider ECT after hearing the evidence from the treating team.

## 2.2 ECT Orders

### 2.2.1 Outcomes of applications for an ECT Order

In 2015/16 the MHT heard a total of 707 applications for an ECT Order. There was one matter where the Tribunal determined that it did not have jurisdiction to conduct a hearing (since the patient was not subject to a compulsory treatment order at the time of the hearing). The following graphs provide details of the ECT Orders made and refused, the duration of Orders, number of ECT treatments granted, and timeframes for the hearing of applications.

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 other than with ECT. As shown in the figures in Table 9, in about half of matters where an Order was not made, the Tribunal found that treatment was able to be provided in a less restrictive manner.

*Table 8: Determinations regarding compulsory ECT*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| ECT Orders made | 620 | 88% | +13% | 550 | 89% |
| ECT applications refused | 86 | 12% | +26% | 68 | 11% |
| Total ECT Orders made or applications refused | 706 | 100% | +14% | 618 | 100% |

*Table 9: Reasons applications for an ECT Order were refused*

| | 2015–16 | 2014–15 |
|---|---|---|
| Treatment was able to be provided in a less restrictive manner | 56% | 61% |
| Person had the capacity to give informed consent | 40% | 34% |
| Tribunal was provided with insufficient information to make a decision | 4% | 5% |

*Figure 10: Determinations regarding compulsory ECT and reasons when applications were refused*

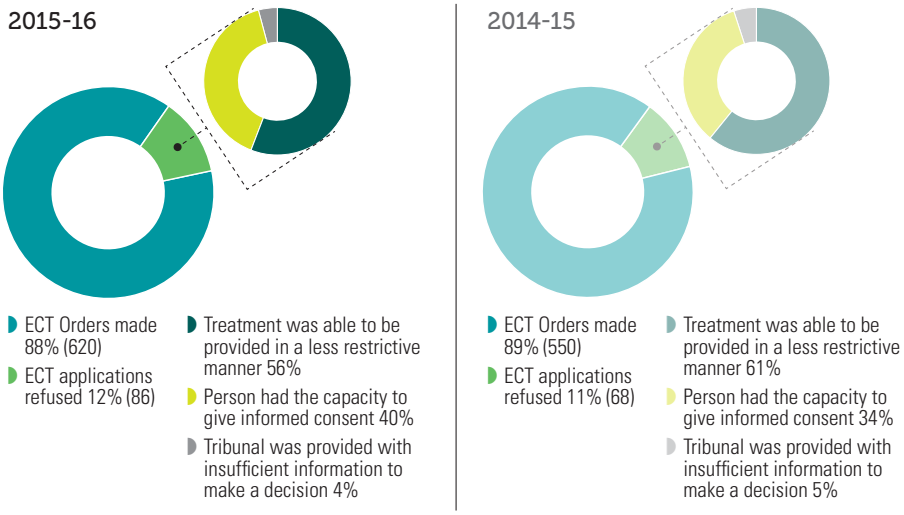



*Table 10: Duration of ECT Orders*

| | 2015–16 No. | 2015–16 % | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|
| 1–6 weeks | 338 | 55% | 268 | 49% |
| 7–13 weeks | 131 | 21% | 135 | 25% |
| 14–20 weeks | 19 | 3% | 14 | 2% |
| 21–26 weeks | 132 | 21% | 133 | 24% |
| Total | 620 | 100% | 550 | 100% |

*Figure 11: Duration of ECT Orders*

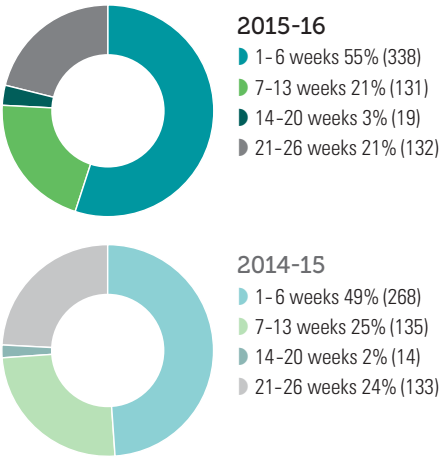
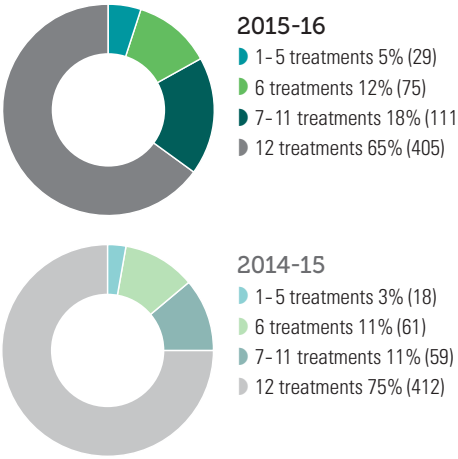



*Table 11: Number of ECT treatments granted*

| | 2015–16 No. | 2015–16 % | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|
| 1–5 treatments | 29 | 5% | 18 | 3% |
| 6 treatments | 75 | 12% | 61 | 11% |
| 7–11 treatments | 111 | 18% | 59 | 11% |
| 12 treatments | 405 | 65% | 412 | 75% |
| Total | 620 | 100% | 550 | 100% |

*Figure 12: Number of ECT treatments granted*




## 2.2.2 Urgent ECT applications

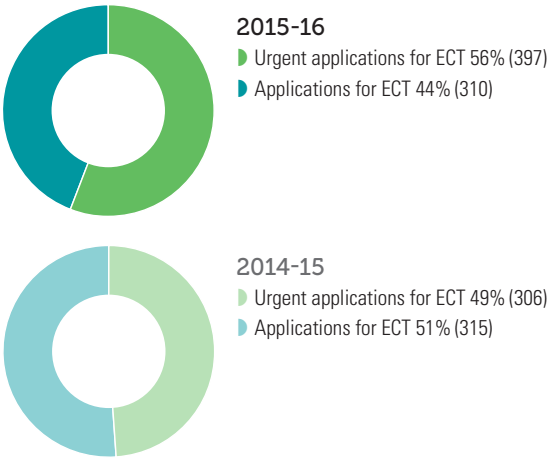
### Urgent ECT applications

The proportion of urgent ECT applications increased from last year and made up almost 60% of applications to the Tribunal for an ECT Order.

*Table 12: Proportion of applications for ECT that were urgent*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Urgent applications for ECT | 397 | 56% | +30% | 306 | 49% |
| Applications for ECT | 310 | 44% | -2% | 315 | 51% |
| Total applications | 707 | 100% | +14% | 621 | 100% |

*Figure 13: Proportion of applications for ECT which were urgent*




### Urgent after-hours ECT applications

An urgent 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 specified public holidays. Generally, urgent after-hours ECT hearings will be conducted as a telephone conference call.

Pursuant to section 95(2) of the Act, urgent applications may only be made if the authorised psychiatrist is satisfied that the treatment is necessary as a matter of urgency:

- to save the life of the patient; or
- to prevent serious damage to the heath of a patient; or
- to prevent the patient from suffering or continuing to suffer significant pain or distress.

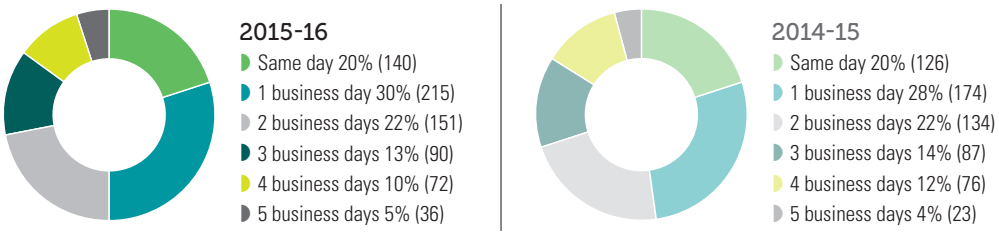
In 2015/16, the Tribunal heard nine urgent after-hours ECT applications. All of the applications were granted.

## 2.2.3 Elapsed time from receipt of ECT applications to hearings

*Table 13: Elapsed time from receipt of ECT applications to hearings*

| | 2015–16 | | 2014–15 | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Same day | 140 | 20% | 126 | 20% |
| 1 business day | 215 | 30% | 174 | 28% |
| 2 business days | 151 | 22% | 134 | 22% |
| 3 business days | 90 | 13% | 87 | 14% |
| 4 business days | 72 | 10% | 76 | 12% |
| 5 business days | 36 | 5% | 23 | 4% |
| Total | 704 | 100% | 620 | 100% |

*Figure 14: Elapsed time from receipt of ECT applications to hearings*




## 2.2.4 ECT Order applications related to a young person under 18 years

### Compulsory patients

During 2015-16, six applications for an ECT Order related to a compulsory patient under 18 years of age. In three of these matters the patient was 17 years old at the time of the hearing. In the other three matters the patient was 16 years old at the time of the hearing. All applications were granted.

### Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2015-16, four applications for an ECT Order related to a young person being treated as a voluntary patient. In three of these matters the patient was 15 years old at the time of the hearing. In the other matter the patient was 17 years old at the time of the hearing. All applications were granted.

## 2.3 Neurosurgery for mental illness

During 2015/2016, the Tribunal received four applications to perform neurosurgery for mental illness (NMI), as shown in the table below. As at 30 June 2016, two applications were pending and listed for hearing in July 2016.

***Table 14:*** *Number and outcomes of applications to perform NMI*

| Applications | Applicant mental health service | Diagnosis | Proposed Treatment | Location of patient | Hearing outcome |
|---|---|---|---|---|---|
| 1 | Monash Alfred Psychiatry Research Centre | Depression | Reposition of deep brain stimulation electrodes | NSW | Granted |
| 2 | St Vincent's Hospital | Obsessive-compulsive disorder | Deep brain stimulation | Victoria | Granted |
| 3 | Monash Alfred Psychiatry Research Centre | Depression | Deep brain stimulation | Victoria | Pending |
| 4 | Monash Alfred Psychiatry Research Centre | Depression | Deep brain stimulation | NSW | Pending |

## 2.4 Security patients

During 2015/16, the Tribunal made 79 determinations in relation to security patients. The Tribunal heard four applications for revocation of a Secure Treatment Order made by or on behalf of the patient (two of which were considered at the patient's 28 day review hearing). In almost all instances, the Tribunal determined that the person should remain a security patient.

***Table 15:*** *Determinations made in relation to security patients by case type*

| | **2015–16 Number** | 2014–15 Number |
|---|---|---|
| **Hearings for a security patient** | | |
| 28 day review | | |
| Remain a security patient | **61** | 82 |
| Discharge as a security patient | **1** | 2 |
| Six month review | | |
| Remain a security patient | **13** | 11 |
| Discharge as a security patient | **1** | 0 |
| Application for revocation by or on behalf of the patient | | |
| Remain a security patient | **4** | 8 |
| Discharge as a security patient | **0** | 2 |
| **Application by a security patient regarding leave** | | |
| Applications granted | **0** | 0 |
| Applications refused | **1** | 0 |

# Case study

## Illustration 2
### Considering serious deterioration or harm

The second treatment criterion requires the Tribunal to consider the consequences if the patient does not receive immediate treatment for their mental illness: will the patient's mental health or physical health seriously deteriorate; will they suffer serious harm; or will another person suffer serious harm? In addition to the Tribunal's decisions regarding this criterion, the Victorian Civil and Administrative Tribunal (VCAT) has also provided guidance in this area.

#### What is the evidential test?

A number of Tribunal decisions have confirmed that the evidential test set down in *Briginshaw v Briginshaw* (1938) 60 CLR 336 is the appropriate test to apply in considering whether the evidence establishes that an asserted deterioration or harm reaches the requisite threshold of seriousness. In XOO [2016] VMHT 50, the Tribunal considered whether the evidence met the Briginshaw test. The Tribunal drew a distinction between XOO's behaviour and personal circumstances that had been directly observed and documented, and the behaviour that XOO denied and had not been directly observed or documented by clinical staff or the community mental health team, but reported by neighbours who had a very antagonistic relationship with XOO. The Tribunal noted it needed to satisfy itself that the evidence was sufficiently relevant and persuasive to prove there was risk of serious deterioration or serious harm, especially keeping in mind that the serious consequence to XOO was continued detention in hospital as a compulsory patient and medication that he did not want to take. In the Tribunal's view, the evidence was not strong enough to find there was a risk of serious deterioration or serious harm.

VCAT has confirmed this approach in *WCH v Mental Health Tribunal (Human Rights) (Amended)* [2016] VCAT 199. VCAT found the *Briginshaw* standard requires a tribunal to actually be persuaded that a fact in issue exists. It must consider the seriousness of the matter at hand and the gravity of the consequences flowing from a particular finding and determine whether the matters in issue have been proven to its reasonable satisfaction. That state of satisfaction is not likely to be reached based on uncertain proofs or evidence or where findings are reached by drawing indirect inferences.

#### Does any expected deterioration need to be immediate and does prevention of serious deterioration mean 'recovery'?

In *CHD* [2015] VMHT 137, the Tribunal considered whether any deterioration suffered needed to be immediate and whether prevention of serious deterioration in fact meant 'recovery'. CHD's legal representative submitted that, given CHD continued to hold the beliefs that the treating team regarded as symptoms of mental illness, despite a period of uninterrupted treatment, treatment could not be regarded as preventing a serious deterioration in his mental health. She also submitted that the relapses CHD suffered in 2012 and 2014 occurred a significant period of time after CHD ceased his medication; hence, they did not reach the requisite level of seriousness. The legal representative also noted that CHD was entitled to make decisions involving a degree of risk and this needed to be understood in the context of a recovery-based approach in which CHD should articulate or define what constitutes recovery for him.

The Tribunal confirmed the Act does not require treatment to achieve a complete resolution of symptoms – containment and prevention of further deterioration is sufficient for this criterion to be met. The Tribunal determined CHD continued to experience symptoms of his mental illness and the treatment he was receiving was greatly reducing the intensity of those symptoms and preventing those symptoms from becoming more acute and causing a major disruption to CHD's life. The Tribunal also confirmed the Act does not require a serious deterioration in a person's mental health to be immediate. The fact that a relapse may take a period of time to unfold does not necessarily detract from its level of seriousness; and while it might mean there is a period of time to respond to a relapse if or when it emerges (such that immediate treatment is not needed in advance) these matters are to be assessed in the context of each person. The Tribunal found that the relapses CHD suffered in 2012 and 2014 were not a period of gradual deterioration in CHD's mental health; instead, it appeared to be a time of sustained disruption in CHD's life that at times reached a level of crisis, and immediate treatment was needed to prevent a recurrence.

#### Each case turns on the circumstances of the individual patient

In *XNC* [2016] VMHT 5, the Tribunal emphasised previous decisions must be read in light of a patient's individual circumstances. The Tribunal distinguished its previous decision in *JMN* [2015] VMHT 29. In that case, the Tribunal found an admission to hospital, in and of itself, would not necessarily meet the definition of serious harm. In *XNC*, the Tribunal confirmed its consideration of the treatment criteria must be grounded in the circumstances of each individual patient. The Tribunal noted that it would be extremely rare for a previous Tribunal decision to provide a precedent regarding the application of the criteria to an individual, as the circumstances of individuals are highly idiosyncratic. The Tribunal considered the decision in *JMN* was not authority for the proposition that the possibility of future hospitalisation will not of itself amount to serious harm. The most that could be said is that the *JMN* decision determined that for that individual patient, based on her particular circumstances, the possibility of future hospitalisation did not amount to serious harm. The clinical and social circumstances of XNC did not resemble those of the patient in *JMN* and the Tribunal did not accept it should follow the decision in *JMN*.

# Case study

## Illustration 3

### Confirming that treatment will be provided if a Treatment Order is made

The third criterion for compulsory treatment requires the Tribunal to assess whether the designated mental health service will provide immediate treatment to the patient if they are subject to a Treatment Order. In most cases, it is clear immediate treatment will be provided. However, where a patient has absconded from hospital or has actively avoided engagement with their community treating team, whether immediate treatment will be provided becomes a difficult and subjective question very much dependent on each patient's individual circumstances. While it is not uncommon for reluctant patients to prevaricate and delay in an effort to put off or avoid unwanted treatment, at a certain point a threshold will be crossed where it can no longer be said that the patient is receiving treatment from the designated mental health service or that there remains at least a reasonable likelihood that the treatment will be provided to the patient if they are subject to a Treatment Order. In the last year, and since the Tribunal's first in-depth examination of this issue in *VOA* [2015] VMHT 56, the Tribunal has continued to develop a body of guiding principles for interpreting criterion 5(c) in cases where a patient is disengaged from treatment. These principles are illustrated in the cases below.

In *LQQ* [2016] VMHT 17, LQQ had a long-standing diagnosis of paranoid schizophrenia. After being discharged from hospital on a Community Treatment Order, she initially engaged with her case manager and attended appointments for her monthly injection of medication and medical reviews. However, LQQ became disengaged and missed an appointment to receive her injection. The treating team made numerous unsuccessful visits to her home and attempts to contact her. A Missing Person's Report was filed with the local police, but the police were not able to locate or contact her. At the time of the Tribunal hearing, LQQ had not received treatment for 10 weeks. The Tribunal considered that in the circumstances of this matter, where the patient's whereabouts are unknown, numerous efforts had been made to contact her and many weeks had passed since she last received treatment, it was difficult to see how it could be argued that the patient was likely to be provided with treatment in the immediate, near or even reasonably foreseeable future as required by criterion 5(c). The Tribunal acknowledged that the treating team had made a number of attempts to locate LQQ; however, these efforts had not been fruitful. The Tribunal's view that by the time of the hearing, despite the treating team having pursued all reasonable avenues to provide treatment, LQQ had not received any treatment for an extended period and there was no reason to believe this would change. In these circumstances, the Treatment Order must be revoked.

The Tribunal's decision in *RCK* [2016] VMHT 9 demonstrates there is no clear cut-off point where it can be said a patient is no longer receiving immediate treatment. The Tribunal must take a holistic look at the patient's circumstances and the treating team's efforts to treat the patient. The treating team's efforts to locate the patient, how long such efforts have been ongoing, current efforts and results are very relevant to the core question of whether treatment is likely to occur. At the time of the hearing, RCK had not received anti-psychotic medication for about two months and was absent without leave from hospital. Although RCK did not attend the hearing, his partner wrote to the Tribunal to explain he was receiving treatment from his general practitioner. In considering whether criterion 5(c) was satisfied, the Tribunal took into account the need for treatment, the likelihood of the treatment being provided and how the Treatment Order could facilitate the provision of the treatment. The treating team gave evidence that they had been making regular phone calls to RCK's mobile phone, had attempted to locate him at his two most recent known addresses and were in the process of attempting to contact RCK's general practitioner to discuss the potential for shared care arrangements. In these circumstances, the Tribunal found the criterion was met even though the patient had not received his medication for two months. The Tribunal ultimately made a 12-week Inpatient Treatment Order, which gave the treating team time to locate RCK and bring him into the inpatient setting to review his condition and status under the Act.

## 2.5 Applications to stop transfer of patient to another service

During 2015/16, five applications to stop the transfer of a patient were received by the Tribunal.

***Table 16:*** *Number and outcomes of applications to stop transfer of patient to another service*

| | 2015–16 | 2014–15 |
|---|---|---|
| Applications granted | 0 | 4 |
| Applications refused | 4 | 5 |
| Applications struck out | 0 | 2 |
| No jurisdiction | 1 | 3 |
| Total | 5 | 14 |

## 2.6 Applications to deny access to documents

During 2015/16, the Tribunal received 51 applications to deny access to documents.

***Table 17:*** *Number and outcomes of applications to deny access to documents*

| | 2015–16 | 2014–15 |
|---|---|---|
| Applications granted | 35 | 23 |
| Applications refused | 2 | 6 |
| Applications struck out | 14 | 4 |
| Total | 51 | 33 |

## 2.7 Applications to transfer a patient interstate

During 2015/2016 there were no applications to transfer a patient interstate.

## 2.8 Applications for review by VCAT

During the year, 20 applications were made to VCAT for a review of a Tribunal decision. Of these applications, 12 were withdrawn and did not proceed, one was struck out and one hearing was vacated. At 30 June 2016, six applications had been determined by VCAT. The Tribunal's decision was affirmed in five matters and revoked in one. There were no applications pending at the end of the financial year.

***Table 18:*** *Applications to VCAT and their status*

| | 2015–16 | 2014–15 |
|---|---|---|
| Applications made | 20 | 24 |
| Applications withdrawn | 12 | 12 |
| Applications struck out | 1 | 2 |
| Applications dismissed | 0 | 1 |
| Hearings vacated | 1 | – |
| Applications proceeded to full hearing and determination | 6 | 7 |
| Applications pending at 30 June | 0 | 2 |

*Table 19: Outcomes of applications determined by VCAT*

| | 2015–16 | 2014–15 |
|---|---|---|
| Decisions affirmed | 5 | 5 |
| Decisions varied | 0 | 2 |
| Orders revoked | 1 | – |

## 2.9 Summary of hearings with determination made

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 20: Number of hearings with determinations made by type*

| | 2015-16 | 2014-15 |
|---|---|---|
| **Type of hearing** | | |
| **Hearings regarding a treatment order** | | |
| Community Treatment Orders made | **3120** | 2588 |
| Inpatient Treatment Orders made | **2485** | 2324 |
| Temporary Treatment Orders / Treatment Orders revoked | **358** | 417 |
| Hearings struck out | **64** | 62 |
| No jurisdiction | **11** | 20 |
| Total | **6038** | 5411 |
| **Urgent applications for electroconvulsive treatment** | | |
| ECT Orders made | **353** | 280 |
| ECT applications refused | **44** | 23 |
| No jurisdiction | **0** | 3 |
| Total | **397** | 306 |
| **Applications for electroconvulsive treatment** | | |
| ECT Orders made | **267** | 270 |
| ECT applications refused | **42** | 45 |
| No jurisdiction | **1** | 0 |
| Total | **310** | 315 |
| **Applications for electroconvulsive treatment for voluntary patients under 18 years of age** | | |
| ECT Orders made | **4** | 0 |
| Total | **4** | 0 |
| **Hearings for a Security Patient** | | |
| Patient remained a Security Patient | **76** | 98 |
| Patient discharged as Security Patient | **2** | 4 |
| Total | **78** | 102 |
| **Applications by security patient regarding leave** | | |
| Applications refused | **1** | 0 |
| Total | **1** | 0 |
| **Applications to deny access to documents** | | |
| Applications granted | **35** | 23 |
| Applications refused | **2** | 6 |
| Applications struck out | **14** | 4 |
| Total | **51** | 33 |
| **Applications to stop transfer to another service** | | |
| Applications granted | **0** | 4 |
| Applications refused | **4** | 5 |
| Applications struck out | **0** | 2 |
| No jurisdiction | **1** | 3 |
| Total | **5** | 14 |
| **Applications to transfer a patient interstate** | | |
| Applications granted | **0** | 1 |
| Total | **0** | 1 |
| **Applications for neurosurgery for mental illness** | | |
| Applications granted | **2** | 3 |
| Total | **2** | 3 |
| **Grand total hearings with determination made** | **6886** | 6185 |

## 2.10 Hearings in person and via video conference

As discussed in Part One, while the Tribunal prefers to conduct hearings in-person, it is not always possible to do so. In 2015/16, around one quarter of hearings were conducted via video conferencing which was a decrease from the previous year.

***Table 21:*** *Hearings conducted in person and via video conference*

| | 2015–16 | | 2014–15 | |
|---|---|---|---|---|
| | **No.** | **%** | No. | % |
| In-person | **5072** | **74%** | 4384 | 71% |
| Video conference | **1801** | **26%** | 1801 | 29% |
| Teleconference | **13#** | **<1%** | –* | –* |
| Total | **6886** | **100%** | 6185 | 100% |

*# Nine of these matters were urgent ECT hearings conducted on weekends. Four matters were conducted when the Tribunal's video-conference functionality ceased to work due to an internet outage.*

** The Tribunal did not record which hearings were conducted by teleconference in 2014-15.*

## 2.11 Attendance and legal representation 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. 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 the following persons if applicable:

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

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

***Table 22:*** *Number and percentage of hearings with patients and support people in attendance*

| | 2015–16 | | 2014–15 | |
|---|---|---|---|---|
| | **No.** | **%** | No. | % |
| Patient | **3993** | **58%** | 3749 | 61% |
| Carer and family member | **1441** | **21%** | 1370 | 22% |
| Carer | **360** | **5%** | –* | –* |
| Family member | **1081** | **16%** | –* | –* |
| Nominated Person | **308** | **4%** | 202 | 3% |
| Legal representative | **1046** | **15%** | 1187 | 19% |
| Interpreter | **236** | **3%** | 205 | 3% |
| Total hearings with determination made | **6886** | **100%** | 6185 | 100% |

** An accurate breakdown of number of carers as opposed to other family members who attended hearings in 2014-15 is not possible as the Tribunal identified some errors in its data collection where carers were being recorded as 'family' rather than 'carer'. This data collection issue was resolved for 2015-16.*

### Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the number of patients that received legal representation and the provider of representation in 2015/16.

*Table 23: Legal representation at hearings*

| | 2015–16 No. | 2015–16 % | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|
| Victoria Legal Aid | **919** | **13%** | 1101* | 18% |
| Mental Health Legal Centre | **73** | **1%** | 40 | 1% |
| Private Lawyer | **36** | **<1%** | 29 | <1% |
| Other Community Legal Centre | **18** | **<1%** | 17 | <1% |
| Total hearings with determination made | **6886** | **100%** | 6185 | 100% |

** Figures for 2014-15 provided by VLA directly*

## 2.12 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 2015/16.

*Table 24: Primary diagnoses of patients who had Tribunal hearings*

| | 2015–16 | 2014–15 |
|---|---|---|
| Schizophrenia | **47%** | 50% |
| Schizo-Affective disorder | **27%** | 21% |
| Bipolar disorder | **11%** | 12% |
| Depressive disorders | **3%** | 4% |
| Delusional disorder | **2%** | 2% |
| Dementia | **1%** | 1% |
| No Diagnosis Recorded | **<1%** | <1% |
| Other organic disorders | **<1%** | <1% |
| Eating disorders | **<1%** | <1% |
| Other | **8%** | 7% |

## 2.13 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 Tribunal 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.

***Table 25:** Hearings adjourned*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Hearings adjourned | **592** | **8%** | +37% | 433 | 7% |
| Hearings with determination made | **6886** | **92%** | +11% | 6185 | 93% |
| Total hearings conducted | **7478** | **100%** | +13% | 6618 | 100% |

***Table 26:** Hearings adjourned with or without the current Order extended*

| | 2015–16 No. | 2015–16 % | % variation of numbers from 2014–15 | 2014–15 No. | 2014–15 % |
|---|---|---|---|---|---|
| Hearings adjourned without Order extended | **174** | **29%** | -21% | 220 | 51% |
| Hearings adjourned with Order extended | **418** | **71%** | +96% | 213 | 49% |
| Total hearings adjourned | **592** | **100%** | +37% | 433 | 100% |

***Figure 15:** Hearings adjourned with or without the current Order extended*

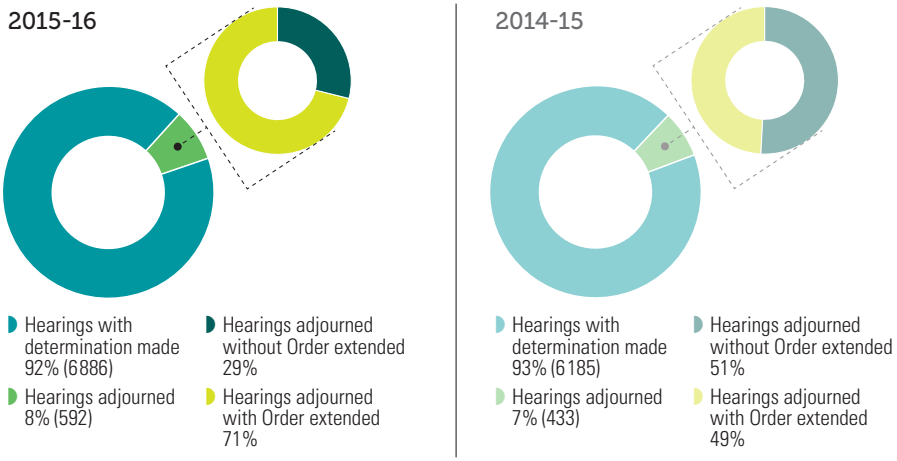
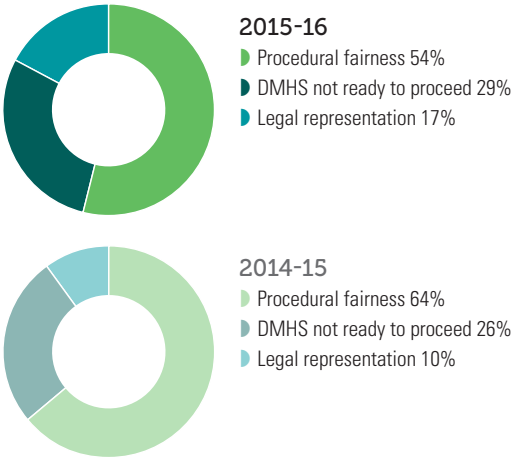


*Table 27: Reasons for adjournments*

| | 2015–16 | 2014–15 |
|---|---|---|
| Procedural fairness | 54% | 64% |
| DMHS not ready to proceed | 29% | 26% |
| Legal representation | 17% | 10% |
| Total | 100% | 100% |

*Figure 16: Reasons for adjournments*




## 2.14 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 Temporary 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 2015/16, there were 12 matters where a Tribunal error was the cause of a hearing not being conducted before a patient's Order expired. In a further two matters, a hearing was not conducted because the treating service failed to notify the Tribunal of a person being made a compulsory patient.

The Tribunal 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 2015/16, there was one matter where as a result of miscommunication the hearing proceeded despite the patient's Treatment Order having ended.

### 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 2015/16, 21 variation hearings were conducted more than 28 days after the variation of the Order. In 14 of these cases, the cause was that the patient's treating team did not advise the Tribunal of the variation to the Treatment Order within time. In seven cases, the cause was Tribunal error.

Additionally, there were three ECT hearings conducted out of time as a result of Tribunal error in listing the matters. In each of these cases the matter was listed and conducted one business day later than the required five business days.

# Case study

## Illustration 4
### Determining the duration of a Treatment Order

The Act does not provide guidelines or criteria for determining the duration of a Treatment Order. The Tribunal considers each matter on a case-by-case basis and makes a decision based on each patient's particular needs and circumstances. Some examples of the considerations the Tribunal routinely takes into account are: current and proposed treatment (including any or proposed changes in treatment) and how long it will take for the patient's mental illness to stabilise with such treatment so that compulsory treatment may no longer be necessary; the estimated time in which a less restrictive means to receive treatment may become reasonably available (such as the establishment or re-establishment of a therapeutic relationship between the patient and their treating team which may make voluntary treatment possible); and the patient's psychiatric history, including the likelihood of their adherence to medication.

Where a patient has lodged an application for revocation, the Tribunal is mindful not to be seen as penalising a patient or dissuading a patient from exercising their right to make an application in future by making a longer Treatment Order than the one the patient has applied to revoke.

In *XPO* [2016] VMHT 48, XPO applied to revoke her Community Treatment Order, which expired in about seven months. XPO told the Tribunal she could be treated voluntarily because she accepted her diagnosis and the need to remain on medication. However, the Tribunal accepted the treating team's evidence that XPO was still in an early stage of recovery, she was about to enter a stressful period of her life, and her history of non-adherence to medication indicated she ceased her medication during previous stressful events. In making its decision, the Tribunal noted its serious concerns about XPO's level of understanding about the connection between ceasing medication and her relapse. The Tribunal agreed with the concerns of her treating team that she required a sustained period of treatment and that her likely adherence to treatment was low in the absence of a Treatment Order. The Tribunal acknowledged the recommendation of the treating team that XPO required a Treatment Order for 12 months. However, XPO had initiated the application to revoke her existing Treatment Order and the Tribunal was reticent to deter her from doing so again by imposing a longer Treatment Order than was presently in place. Given this, the Tribunal ultimately decided on a period of 36 weeks to (approximately) preserve the existing expiry date of her existing Treatment Order. The Tribunal considered that this would also allow an appropriate period for XPO and her treating team to review treatment options and further build their therapeutic alliance. It was also a reasonable amount of time in which to reconsider XPO's compulsory Order.

However, in some cases the Tribunal will consider it appropriate to make a Treatment Order for a longer duration than the existing Order that is the subject of the application for revocation. At the time of hearing in *GSG* [2016] VMHT 27, GSG had approximately six weeks until his Community Treatment Order expired. GSG had applied for a revocation of his Treatment Order because he did not believe he had a mental illness, did not want to take medication and saw no risks with ceasing his medication. The Tribunal was satisfied the criteria for compulsory treatment were met and made a Community Treatment Order. The Tribunal made a 52-week Order, which was well in excess of the time remaining on the Order GSG had applied to revoke. In explaining its decision, the Tribunal noted it usually would not exceed the duration of the existing Order. However, in this case the Order was due to expire shortly. The treating team had also told the Tribunal that they were planning to apply for a further Treatment Order. Having regard to the principles of the Act, in particular section 11(b), which emphasises therapeutic outcomes, the Tribunal considered the therapeutic relationship between GSG and his treating team was more likely to be advanced if the treating team were not required to shortly initiate further proceedings under the Act. Given GSG's recent history of multiple admissions, combined with his longstanding reluctance to accept his mental illness and lack of acknowledgement of the serious risks associated with non-adherence with treatment, the Tribunal considered a longer Treatment Order was appropriate in this case.

The Supreme Court recently looked at the question of whether the Tribunal had the power to make a longer Treatment Order than the one the patient had applied to revoke. In *Daniels v Eastern Health* [2016] VSC 148, the Court concluded there was no basis for finding the Victorian Parliament had by inadvertence overlooked the possibility that, in circumstances where the Tribunal decides to make a Treatment Order where there has been an application to revoke, it would make a new Treatment Order which operates beyond the expiry date of the extant Treatment Order. The power to make an Order is unambiguous in section 55(1); the Tribunal's power to make a Treatment Order is not read down when there is an application for revocation. In addition, each hearing is a *de novo* hearing – that is, a fresh hearing – and the Tribunal's assessment of whether the treatment criteria are met is determined as at the date of the hearing.

# Part 3 Embedding the mental health principles in the Tribunal's work

**The Act sets down 12 mental health principles to guide the provision of mental health services and to which persons performing duties or functions or exercising powers under the Act, including the Tribunal, must have regard.**

This Part sets out how particular mental health principles inform and underpin the work of the Tribunal across the whole organisation – with a particular focus on how Tribunal hearings and the work of the Tribunal's administrative staff reflect those principles relevant to enhancing consumer participation, recovery and respect for rights, and autonomy.

Section 11 of the Act contains the mental health principles. This part focuses on several of these principles, namely that when a person is receiving mental health services they should:

- be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred (s. 11(1)(a));
- be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life (s. 11(1)(b));
- be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions and their views and preferences should be respected including decisions that involve a degree of risk (s. 11(1)(c) and (d));
- have their rights, dignity and autonomy respected and promoted (s. 11(1)(e)); and that
- carers (including children) should be involved in decisions about assessment, treatment and recovery wherever possible, and should have their role recognised, respected and supported (s. 11(1)(k) and (l)).

The Tribunal's commitment to reflecting the principles in its hearing and administrative functions is highlighted in the Tribunal's vision, namely 'promoting rights by ensuring the participation of people with mental illness and their carers in decision making', and our strategic priorities, which include 'maximising opportunities for consumer and carer participation.'

## 3.1 Enhancing consumer and carer participation and engagement

Improving consumer and carer participation and engagement is a priority for the Tribunal. The Tribunal's work in this area demonstrates an ongoing commitment to involving consumers in all decisions about their treatment and recovery and supporting them to make or participate in such decisions, and to respecting and promoting the rights, dignity and autonomy of consumers.

The appointment of a Consumer Consultant was 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 Advisory Group (TAG) continues to meet on a bi-monthly basis. The TAG membership includes:

- two current consumers with recent or current lived experience
- two current carers with current lived experience
- two consumer workers
- two carer workers.

A senior Tribunal member and a Tribunal staff member (usually the Consumer Consultant) also attend the meetings.

The Tribunal held its inaugural Consumer and Carer Forum in August 2015. Consumers and carers were invited to join the Tribunal to reflect on the first year of operation of the new Act and discuss future opportunities for engagement. The Forum was a great success and planning is underway for a second Forum in November 2016.

Over the last year, the TAG has developed a number of initiatives to encourage consumer and carer attendance and participation at hearings. These initiatives are at varying stages of completion and include:

- reviewing the content and format of the information the Tribunal provides prior to hearings to consumers, carers, nominated persons and other persons who are entitled to receive notification of a hearing
- translating Tribunal information into languages other than English
- developing a survey to ascertain consumers and carers' experience of Tribunal hearings. The results of the survey will be analysed with a view to improving Tribunal practice and procedure.

The Tribunal also intends to pursue a number of new projects, including:

- developing information specifically targeted towards nominated persons, carers and families explaining what their rights are when the people they care for attend Tribunal hearings
- producting information in alternate formats, such as videos, podcasts and/or an interactive guide
- reviewing the Tribunal's website content and structure to ensure that it is useful and accessible.

In the longer term, the Tribunal's is committed to evolving its approach to consumer and carer engagement and to moving from consultation to greater collaboration with and empowerment of consumers and carers in the development of the Tribunal's services.

## 3.2 The Continuous Improvement Performance Model and Substantive Decision Making

The development of a Continuous Improvement Performance Model for members (CIPM) grew from a recognition that the Tribunal needed to develop an additional suite of resources that articulate and assist members to perform their role in accordance with a clear set of standards, with those standards being grounded in the principles of the Act.

A key resource within the CIPM framework provides members with guidance on exploring the implications of the mental health principles in the circumstances of individual patients. This integrates consideration of the principles within hearings and helps members to incorporate the principles when considering the criteria that govern the making of Orders - whether Treatment Orders or ECT Orders.

A number of recent statements of reasons highlight the way in which consideration of the mental health principles in section 11 of the Act is being integrated within Tribunal decision-making.

### *QDE* [2015] VMHT 207 – making decisions involving a degree of risk

In *QDE*, the Tribunal had particular regard to the 'dignity of risk' principle in section 11(1)(d) in reaching a conclusion that there were less restrictive means reasonably available to enable the patient to receive immediate treatment (the fourth treatment criterion in section 5 of the Act).

In this case, the patient expressed particular frustration and distress about being on a Treatment Order. In the statement of reasons, the Tribunal observed that:

> QDE expressed her desperation graphically at one point in the hearing when she said *'if I cease my medication I am treated involuntarily. If I take my medication I am still treated involuntarily. This has been going on for too long!'* Her distress was not difficult to comprehend.

After noting that the patient had recovered sufficiently to have a reasonable chance of resuming a relatively normal life in the wider community, as well as her intention to pursue treatment with lithium therapy under the supervision of her general practitioner with whom she had a good relationship, the Tribunal stated as follows:

> The Tribunal too, has been acutely aware of the ethical dimension of the case before it. In that context, and in accordance with the risk principle, the Tribunal takes the view that QDE's decisions with respect to her treatment and recovery should be respected, even though, as in this case, they carry with them a measure of risk. Her interests, and those of wider society as reflected in Victorian mental health legislation, now favour her liberty.

### *YGJ* [2015] VMHT 211 – respect for the views and preferences of the person receiving treatment

Again considering the fourth treatment criterion, the Tribunal noted that the mental health principles clearly state that voluntary treatment is to be preferred. It noted that the patient told the Tribunal she would continue the necessary treatment for her mental health if advised to do so by her private doctor with whom she had developed a good therapeutic relationship. According to the Tribunal, given the patient's condition could be difficult to treat, allowing her to choose her own medical practitioner 'is likely to lead to a better outcome'.

Accordingly, the Tribunal explained:

> *Ultimately, YGJ had a right to have her treatment managed by the practitioner of her choice. In arriving at this conclusion the Tribunal had regard to the mental health principles set out in section 11 of the Act, specifically the principle that persons receiving mental health treatment should have their views and preferences for treatment respected, and should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. In this instance, the risk is mitigated by the fact that YGJ has regular contact with her adult children who can assist her to seek further treatment should this become necessary.*

### *KQQ* [2016] VMHT 47 – the person receiving treatment should be involved in all decisions

The case of *KQQ* highlights the relevance and application of the mental health principles in a different context. In this case, the Tribunal had regard to the mental health principles, as well as the rules of procedural fairness, in deciding to adjourn an urgent application for ECT. The Tribunal highlighted the significant limits on the patient's ability to prepare for and participate in the hearing as a result of the hearing having been listed so urgently in response to the mental health service's request. For example, the patient had not read the clinical report and had only had a very limited opportunity to discuss ECT with his treatment team. The Tribunal held that the circumstances relied on by the treating team to demonstrate urgency did not meet the threshold in the Act, thereby allowing the Tribunal greater discretion regarding how quickly the application should be heard and determined.

In its statement of reasons, the Tribunal concluded:

> The Tribunal decided in this instance that granting an urgent hearing of the application would constitute a failure to provide procedural fairness. In reaching this decision, the Tribunal was also guided by the mental health principles in the Act, particularly section 11(1)(c) which provides that persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected. This decision was made in the context that the Tribunal decided that the test for an urgent application contained in section 95(2)(c) was not met. In other words, this was not a case in which the urgency of the application met the threshold required to dispense with the requirements of procedural fairness […].

### *FVB* [2016] VMHT 16 – risk must be considered alongside, and not in place of, the mental health principles

In *FVB* the Tribunal had regard to the mental health principles in a case which illustrates the challenges that arise in cases involving patients with multiple, complex needs who have been subject to lengthy periods of inpatient treatment, often in more restrictive settings. In such cases, there may be a number of challenges in transitioning to less restrictive settings, especially where the past actions of a person indicate that the symptoms of their mental illness can give rise to a significant risk of harm to the person or to others.

In this case the Tribunal observed:

> *FVB's continued detention [in the current restrictive environment] appears contrary to the principles of the Act regarding the provision of mental health services, in particular that services should be provided in the least restrictive way possible, with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in the community, and that the person's individual needs should be recognised and responded to.*
>
> *In addition, the evidence provided to the Tribunal was that FVB's risks were limiting the provision of services to support and assist FVB in transitioning him to other, less restrictive environments. While considering that risks were rightly a factor, focus on the risks was not helpful for FVB; managing and incorporating the consideration or risk into planning for FVB should be possible and part of the discussion, rather than being the final position or answer when various accommodation options were considered.*

## 3.3 Solution-focused hearings

Solution-focused hearings aim to engage participants as active partners in the decision-making process of the Tribunal. A solution-focused approach is not about miscasting the Tribunal as a source of solutions, but rather about recognising that hearings can be conducted in a manner that facilitates participants in hearings discussing, identifying and committing to future actions or solutions. This approach 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 the underlying issues.

Accordingly, solution-focused hearings complement and reflect the mental health principles. In particular, they contribute to the best possible therapeutic outcomes and promote recovery and full participation in hearings and community life. In addition, they are an integral way of involving consumers in all decisions about their treatment and recovery and of supporting them to make or participate in those decisions. Perhaps most importantly, solution-focused hearings respect consumers' rights, dignity and autonomy.

### Further development of the *Guide to Solution-focused hearings in the Mental Health Tribunal*

In 2014, the Tribunal released *A Guide to Solution-Focused Hearings in the Mental Health Tribunal*. The Tribunal intended the guide to be a starting point in the development of a comprehensive framework to govern how the Tribunal would perform its functions and approach its decision-making. The Tribunal recognised that this resource would develop and evolve as the Tribunal gained more experience with the Act and received more feedback regarding the expectations of participants in hearings. This year, the Tribunal commenced and progressed work on enhancing the guide to recognise and respond to the fact that different groups of consumers have different needs.

This year the Tribunal circulated for targeted release a discussion paper on solution-focused hearings for older people. The Tribunal consulted widely with relevant organisations and received submissions and comments from a range of internal and external stakeholders. Next year the Tribunal anticipates expanding the solution-focused hearings guide to include a dedicated section on solution-focused hearings and older persons.

This will fit alongside work completed this year to develop guidance on conducting solution-focused hearings for young people that is also based on a comprehensive consultation process. It is expected that this addition to the Guide will have been published by the time this Annual Report is released.

Aside from reflecting the principles that the Tribunal has chosen to highlight in this Annual Report, its work on solution-focused hearings for older persons and younger people also illustrates the Tribunal's commitment to developing hearings and administrative procedures that reflect those mental health principles that emphasise the diversity of people receiving treatment and the especially high benchmark they set for responding to the particular needs of children and young people. Specifically:

- persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to (s. 11(1)(g))
- children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible (s. 11(1)(i))
- children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected (s. 11(1)(j)).

# Solution-focused case study

The hearing was for a 24-year-old patient who was subject to a Temporary Treatment Order (varied from an Inpatient Temporary Treatment Order to a Community Temporary Treatment Order less than a week before the hearing). The patient lived in youth accommodation designed for young people who wish to study but who are either homeless or at risk of homelessness. He had virtually no contact with his family. The patient had some history of engagement with mental health services prior to this most recent admission.

The service was seeking an Order for three months on the basis that the patient did not accept that he had suffered a relapse of his mental illness, noting that the patient believed he suffered from anxiety for which he did not need medication. At the time of the hearing, the patient was receiving depot and oral medication.

The patient attended the hearing with the manager and two case managers from the accommodation service. The patient told the Tribunal that he could not recall the events surrounding his return to hospital, did not think he needed to come to hospital and did not require treatment for mental illness. He was concerned about the side effects of his medication and that the medication obstructed his work and study.

The staff from the patient's accommodation agreed that the patient was struggling to deal with his mental illness and that he needed support. It was acknowledged that previously there had been little or no co-ordination between the patient's treating team and the accommodation service. There was discussion about the patient's lack of understanding of his mental illness and early warning signs. There was also an occupational therapist's report indicating that the patient did not respond to coercion and one of the accommodation case managers confirmed that the patient preferred independence.

During the hearing there was discussion about the importance of co-ordination between the mental health team and the team at the accommodation. The Tribunal was told that the patient was a very able and well-regarded person at his accommodation and there was evidence that he responded well when he was in an environment that he wanted to be in. There was discussion with the patient and the case managers from the accommodation service about dealing with any concerns about treatment (including side effects) with the treating team.

The Tribunal revoked the Order on the basis that section 5(d) was not satisfied. The patient's stable accommodation, supportive surroundings and case managers, and the fact that he did not respond to compulsion, were important factors in the Tribunal's considerations. In this matter, all participants in the hearing used the Tribunal process as an opportunity to further share their own perspective and listen to the perspective of others in such a way as to be involved and engaged in the very positive and important outcome. As all participants left the hearing, the doctor from the treating team gave the patient a 'high five'.

## 3.4 Case management

Case management is an integral part of ensuring that hearings are participatory and solution-focused. Case management is an additional process applied to cases with an added level of complexity to support the participation of consumers, carers and nominated persons and to facilitate the readiness of the matter to proceed on the day of the hearing.

Case management may involve a range of strategies including: allocating additional time for the hearing; contacting relevant parties and agencies well in advance of the hearing to ensure their availability to participate in the hearing; requesting all reports and submissions earlier than usual to maximise preparation time; requesting that such reports or submissions provide answers to specific questions; and preparing a case management briefing note for the division outlining the background, legal history and any statements of reasons or reports from previous Tribunal divisions.

As the following case study illustrates, case management can contribute to ensuring that the right information and participants are at hearings, maximising the opportunity to facilitate discussion with relevant persons and agencies about how to work towards a less restrictive means of treatment for patients and ultimately towards their recovery and full participation in community life.

# Case management of hearing involving long-stay patients

**Hearings for a small group of 'long-stay' patients are handled in accordance with a case management strategy developed between the Tribunal, relevant services and, for those who are represented, Victoria Legal Aid.**

**The common characteristic across this group of patients is that they have been inpatients for an extended period of time (in some cases many years) and their transition to the community will necessarily involve a number of agencies. The Tribunal is clear about its role being limited to the making of Orders; however, it is also committed to facilitating a hearing process that provides a forum for discussion and contributes to maintaining focus, and sometimes momentum, on the development of a discharge plan. This is not only a sensible use of the Tribunal's hearings: as the body being asked to make Orders that might continue an already protracted inpatient stay, the Tribunal also has a legitimate interest in satisfying itself that these matters are being addressed.**

**One patient in this group had two hearings over a six-month period and had been an inpatient for several years. Following the first of the two most recent hearings, the Tribunal wrote to the parties providing a detailed outline of the information it would require for the next hearing. It also advised that it proposed to join as a party to the next hearing the service that would be responsible for treating the patient whenever she left the current service (the 'receiving service'). The receiving service was also notified that it would be joined as a party to the next hearing and required to provide certain information. The Tribunal stressed that this information could be provided in collaboration with the current service.**

**At the most recent hearing, the current and the receiving service presented a comprehensive treatment plan and discharge strategy that had been developed in consultation between the two services, the patient and her family. The plan was creative (for example, it involved 'staff exchanges' in the lead up to discharge to share strategies about how best to support and treat the patient). It was also long-term and had considered a number of contingencies and issues. The expectation was that transition from the current to the receiving service could happen in four to six weeks.**

**The transition plan was the product of the exemplary efforts of both the current and the receiving service, which worked in close collaboration with the patient, her Victoria Legal Aid lawyer and her family. The parties acknowledged that the Tribunal's case management approach used for these hearings had played an important role in advancing progress in what was an exceptionally complicated set of circumstances.**

## 3.5 Report for patients in Secure Extended Care Units (SECU)

The Tribunal's Rules and Practice Notes require the treating team to prepare a clinical report before every Tribunal hearing. The clinical report is a further way of ensuring that, as well as exploring whether all the criteria for compulsory treatment apply, hearings focus on the patient's path towards the best therapeutic outcomes, less restrictive treatment and, ultimately, recovery.

For hearings regarding Treatment Orders the clinical report is called the Report on Compulsory Treatment. The Tribunal has provided services with a comprehensive template to guide the preparation of these reports. The template contains a number of questions about the patient's social circumstances, whether there are any less restrictive means of treatment and the patient's treatment and recovery plan.

During 2015/16, the Tribunal consulted on a tailored report for SECU patients which is expected to be finalised and implemented during 2016/17. The development of this report arises from the recognition that particular issues and complexities arise given the usually complex circumstances and presentations of SECU patients and the rehabilitation focus of treatment and support.

The new clinical report template for SECU patients will build on the standard Report on Compulsory Treatment to include additional focus on issues such as:

- the agencies or services (including rehabilitation, drug and alcohol services, occupational programs) that are currently involved or need to be involved in the patient's care
- transitional accommodation plans for the patient (and the community supports needed to achieve this transition)
- any obstacles to plans to discharge from SECU and what is being done to address them
- strategies the Tribunal can implement to enable hearings to be better used as a forum to monitor progress and define steps towards less restrictive treatment.

The Tribunal expects the new SECU report to contribute directly to the integration of the mental health principles in hearings for SECU patients, particularly the principles around bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life and ensuring that treatment occurs in the least restrictive way possible, with voluntary assessment and treatment preferred.

To assist in enhancing the Tribunal's approach to hearings involving SECU patients, the Tribunal held a twilight seminar in May 2016: *'The model of treatment in secure extended care units'*. Dr Anthony Cidoni and Brigid Bosley from Dandenong Hospital SECU (the largest SECU in Victoria) provided Tribunal members with an overview of service design and delivery in SECU, including entry and exit pathways. They also participated in a question and answer session focusing on the particular issues that can arise in the context of Tribunal hearings.

# Appendix A
## Financial Summary

The table below provides a summary of the Tribunal's funding sources and expenditure for 2015/16 and 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**

| | 2015/16 | 2014/15 |
|---|---|---|
| **TOTAL** | **$8,109,551** | $7,600,000 |

| Expenditure | | |
|---|---|---|
| Full and part-time member salaries | **$1,343,608** | $1,586,467 |
| Sessional member salaries | **$3,260,481** | $2,920,188 |
| Staff Salaries (includes contractors) | **$1,495,640** | $1,418,071 |
| **Total Salaries** | **$6,099,729** | $5,924,726 |
| Salary Oncosts | **$1,458,305** | $1,036,571 |
| Operating Expenses | **$548,733** | $584,707 |
| Depreciation* | **$0** | $50,409 |
| **TOTAL** | **$8,106,767** | $7,596,413 |
| Balance | **$2,784** | $3,587 |

** Depreciation is centrally managed within the Department of Health and Human Services and is no longer reflected in this year's financial summary.*

# 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 *(resigned 18 December 2015)* |
| **Senior Members** | |
| 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 2021 |
| Ms Kim Magnussen | 25 Feb 2011 – 24 Feb 2021 |

| **Part-Time Members – Psychiatrist** | Period of Appointment |
|---|---|
| Dr Sue Carey | 25 Feb 2011 – 24 Feb 2021 |
| Dr Nicholas Owens | 10 June 2013 – 9 June 2018 *(transitioned to sessional membership 19 April 2016)* |

| **Part-Time Members – Community** | Period of Appointment |
|---|---|
| Mr Duncan Cameron | 10 June 2008 – 9 June 2018 *(transitioned to sessional membership 13 July 2016)* |
| Mr Ashley Dickinson | 25 Feb 2011 – 24 Feb 2021 |
| Dr Diane Sisely | 25 Feb 2006 – 24 Feb 2021 |
| Ms Helen Walters | 10 June 2013 – 9 June 2018 |

| **Sessional Members – Legal** | Period of Appointment |
|---|---|
| Mr Darryl Annett | 25 Feb 2016 – 24 Feb 2021 |
| 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 *(retired 24 February 2016)* |
| Mr David Eldridge | 10 June 2008 – 9 June 2018 |
| Ms Jennifer Ellis | 25 Feb 2016 – 24 Feb 2021 |
| Dr Ian Freckelton | 23 July 1996 – 24 Feb 2021 |
| Mr Graeme Bailey | 21 Feb 1989 – 24 Feb 2016 *(retired 24 February 2016)* |
| Ms Susan Gribben | 5 Sept 2000 – 9 June 2018 |
| Ms Tamara Hamilton-Noy | 25 Feb 2016 – 24 Feb 2021 |
| 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 Anthony Lupton | 25 Feb 2016 – 24 Feb 2021 |
| 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 2021 |
| Ms Alison Murphy | 25 Feb 2016 – 24 Feb 2021 |
| Mrs Anne O'Shea | 8 Sept 1987 – 9 June 2018 |
| Mr Robert Phillips | 29 June 1999 – 24 Feb 2021 |
| Mr David Risstrom | 25 Feb 2006 – 24 Feb 2021 |
| Mr Nick Sciola | 7 Sept 2004 – 9 June 2018 |
| Ms Janice Slattery | 25 Feb 2006 – 24 Feb 2021 |
| 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 2021 |
| 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 |
| Dr Bethia Wilson | 10 June 2013 – 9 June 2018 |
| Ms Camille Woodward | 25 Feb 2011 – 24 Feb 2021 |
| Prof Spencer Zifcak | 8 Sept 1987 – 24 Feb 2021 |

| **Sessional Members – Psychiatrist** | Period of Appointment |
|---|---|
| Dr Mark Arber | 25 Feb 2016 – 24 Feb 2021 |
| Dr Robert Athey | 9 Oct 2012 – 24 Feb 2021 |
| Dr David Baron | 22 Jan 2003 – 24 Feb 2021 |
| 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 |
| Dr Tom Callaly | 11 March 2014 – 9 June 2018 |
| Dr Robert Chazan | 25 Feb 2016 – 24 Feb 2021 |
| Dr Eamonn Cooke | 14 July 2009 – 9 June 2018 |
| Dr Blair Currie | 9 Oct 2012 – 24 Feb 2021 |
| Dr Elizabeth Delaney | 25 Feb 2011 – 24 Feb 2021 |
| Dr Astrid Dunsis | 25 Feb 2006 – 24 Feb 2021 |
| Dr Leon Fail | 9 Oct 2012 – 24 Feb 2021 |
| Assoc Prof John Fielding | 11 March 2014 – 9 June 2018 |
| Dr Joanne Fitz-Gerald | 25 Feb 2016 – 24 Feb 2021 |
| 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 2021 |
| Assoc Prof Anne Hassett | 11 March 2014 – 9 June 2018 |
| Dr Harold Hecht | 9 Oct 2012 – 24 Feb 2021 |
| Dr David Hickingbotham | 25 Feb 2016 – 24 Feb 2021 |
| Prof. Malcolm Hopwood | 5 Sept 2010 – 24 Feb 2021 |
| Dr Sylvia Jones | 27 July 2010 – 24 Feb 2021 |
| Dr Stephen Joshua | 27 July 2010 – 24 Feb 2021 |
| Dr Spridoula Katsenos | 9 Oct 2012 – 24 Feb 2021 |
| Dr Miriam Kuttner | 7 Sept 2004 – 9 June 2018 |
| Dr Stella Kwong | 29 June 1999 – 24 Feb 2021 |
| Dr Jenny Lawrence | 9 Oct 2012 – 24 Feb 2021 |
| 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 Ahmed Mashhood | 25 Feb 2016 – 24 Feb 2021 |
| Dr Barbara Matheson | 9 Oct 2012 – 24 Feb 2021 |
| 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 – 24 Feb 2021 |
| Prof Daniel O'Connor | 27 June 2010 – 24 Feb 2021 |
| Dr Gunvant Patel | 11 March 2014 – 9 June 2018 |
| Dr Tom Peyton | 19 May 1998 – 24 Feb 2016 *(retired 24 February 2016)* |
| Dr Philip Roy | 09 Oct 2012 – 24 Feb 2021 |
| Dr Amanda Rynie | 25 Feb 2016 – 24 Feb 2021 |
| Dr Sudeep Saraf | 25 Feb 2016 – 24 Feb 2021 |
| Dr Rosemary Schwarz | 25 Feb 2016 – 24 Feb 2021 |
| Dr Joanna 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 – 9 June 2018 |
| Dr Jan Steel | 27 July 2010 – 24 Feb 2016 *(retired 24 February 2016)* |
| Dr Jennifer Torr | 11 March 2014 – 24 Feb 2021 |
| Dr Maria Triglia | 25 Feb 2011 – 9 June 2018 |
| Prof Dennis Velakoulis | 2 Dec 2008 – 24 Feb 2016 *(retired 24 February 2016)* |
| Dr Ruth Vine | 9 Oct 2012 – 24 Feb 2021 |
| Dr Sally Wilkins | 25 Feb 2016 – 24 Feb 2021 |

| **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 2021 |
| Ms Sara Duncan | 10 June 2013 – 9 June 2018 |
| Ms Margaret Fowler | 25 Feb 2011 – 24 Feb 2016 *(retired 24 February 2016)* |
| Ms Elizabeth Gallois | 5 Sept 2000 – 9 June 2018 |
| Mr John Griffin | 25 Feb 2011 – 24 Feb 2021 |
| Prof Margaret Hamilton | 25 Feb 2016 – 24 Feb 2021 |
| Ms Tricia Harper | 5 Sept 2000 – 9 June 2018 |
| Mr 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 2021 |
| Ms Danielle Le Brocq | 10 June 2013 – 9 June 2018 |
| Mr John Leatherland | 25 Feb 2011 – 24 Feb 2021 |
| 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 2021 |
| 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 2021 |
| Dr Kylie McShane | 29 June 1999 – 24 Feb 2021 |
| Ms Sarah McWilliams | 25 Feb 2016 – 24 Feb 2021 |
| Dr Patricia Mehegan | 10 June 2008 – 9 June 2018 |
| Ms Helen Morris | 20 April 1993 – 24 Feb 2021 |
| Ms Margaret Morrissey | 25 Feb 2011 – 24 Feb 2021 |
| Mr Aroon Naidoo | 25 Feb 2016 – 24 Feb 2021 |
| Mr Jack Nalpantidis | 23 July 1996 – 24 Feb 2021 |
| 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 2021 |
| Dr Jim Sparrow | 7 Sept 2004 – 9 June 2018 |
| Ms Veronica Spillane | 25 Feb 2011 – 24 Feb 2021 |
| Ms Helen Steele | 25 Feb 2016 – 24 Feb 2021 |
| 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 2021 |
| Assoc Prof Penelope Weller | 10 June 2013 – 9 June 2018 |

| **Registered Medical Members** | Period of Appointment |
|---|---|
| Dr Adeola Akadiri | 1 July 2014 – 9 June 2018 |
| Dr Trish Buckeridge | 1 July 2014 – 9 June 2018 |
| Dr Louise Buckle | 1 July 2014 – 9 June 2018 |
| Dr Kaye Ferguson | 25 Feb 2016 – 24 Feb 2021 |
| Dr Naomi Hayman | 1 July 2014 – 9 June 2018 |
| Dr John 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 Sandra Neate | 25 Feb 2016 – 24 Feb 2021 |
| Dr Debbie Owies | 1 July 2014 – 9 June 2018 |
| Dr Stathis Papaioannou | 1 July 2014 – 24 Feb 2021 |

# Appendix C
## Compliance Reports

In 2015/16, the Tribunal maintained 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 hearing-related information from persons who have been the subject of a hearing conducted by the Tribunal. It should be noted that certain documents may be destroyed or transferred to the Public Records Office in accordance with the *Public Records Act 1973*.

Where possible, the Tribunal provides information administratively without requiring a freedom of information request. This financial year, the Tribunal received six 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; and in one matter the Tribunal did not hold the documents that were the subject of the request.

#### How to lodge a request

The Tribunal encourages members of the public to contact the Tribunal before lodging a request under the FOI Act to ascertain if the documents may be released administratively.

Otherwise, a freedom of information request must be made in writing, must clearly identify the documents being requested and be accompanied by the application fee ($27.20 from 1 July 2015). 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 2015/16 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@health.vic.gov.au

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

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

Phone: 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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