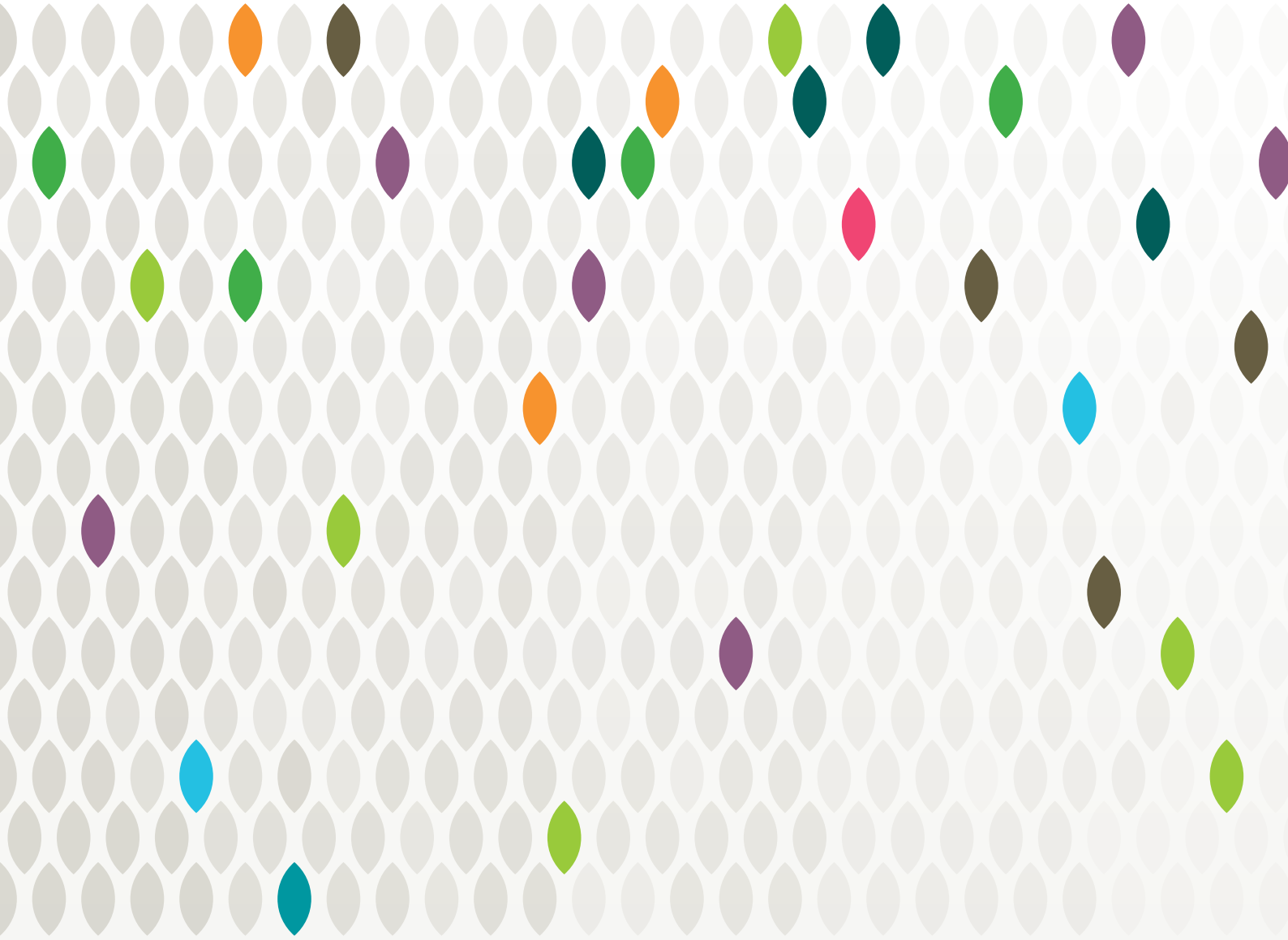
Mental Health Tribunal

2016-2017 Annual Report

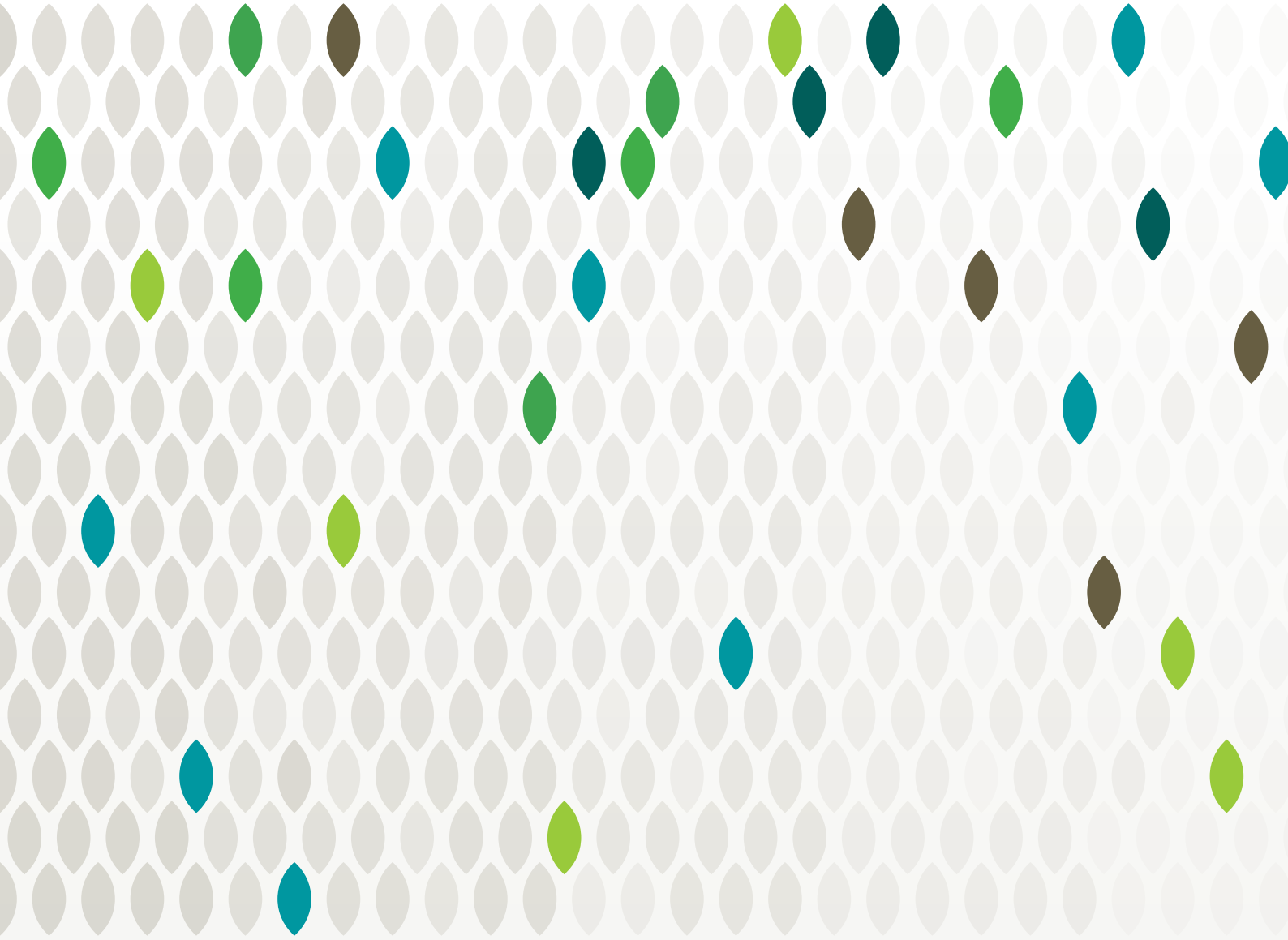


Mental Health Tribunal

INSIDE FRONT COVER
(BLANK)

Mental Health Tribunal

2016-2017 Annual Report



Mental Health Tribunal

Level 30
570 Bourke St, Melbourne
Victoria 3000 Australia

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

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

12 July 2017

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 2016 to 30 June 2017.

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

Victoria's *Mental Health Act 2014* (the Act) has now been in place for three years. As we move beyond the initial phase of its operation we have reached a critical point in the Act's evolution and application. While many challenges have been met, it is still relatively 'early days' and there remains much that needs to be done to fully realise its reform objectives.

There is now widespread familiarity with the Act, but this also means that the intense focus and reflection generated by its enactment has abated and as a result there is the potential for historical and entrenched approaches to once again become dominant. All of us working under the Act, in our different capacities and circumstances, need to continue to reflect on how we can best uphold the principles of the Act and promote the participation of people with mental illness and their carers in decisions about compulsory treatment. We must be willing to be self-critical of our performance, to be transparent in our decision-making, and to use our familiarity with the Act as a platform from which to engage with its more complex reforms and rise to the challenges it poses.

Within this context, the past 12 months have been a period of consolidation for the Mental Health Tribunal (the Tribunal). We have experienced another extremely busy year, with the number of hearings listed and the number of hearings conducted both increasing by nearly 5%. However, the stability and effectiveness of the operating procedures we have put in place across our organisation mean that we have also been able to reflect upon and explore how we can perform our functions more effectively.

The Tribunal Advisory Group (TAG) has played an essential role in this process of reflection. Members of the TAG include consumers, carers and consumer and carer consultants. Together with the Tribunal's Consumer and Carer Engagement Officer, the TAG identifies issues that require attention, advises on improvements we can make to our procedures and practices, and designs and facilitates our consumer and carer forum. Our 2016 forum focused on consumers, with the theme 'Enhancing our Act'. In 2017 the forum will focus on improving the inclusion of carers and family members in Tribunal hearings.

A further major initiative led by the TAG over this year is the design of a survey tool to facilitate feedback from consumers and carers regarding the extent to which they feel involved and respected in Tribunal hearings. An initial pilot of the survey, followed by its full rollout, is planned for the coming year. Across the Tribunal we are all looking forward to receiving the perspectives provided by the survey, and using this feedback to inform further improvements to our practice and procedures. As part of our ongoing commitment to transparency and accountability, we will share the results and feedback from the survey.

Last year I highlighted the development of the Continuous Improvement Performance Model: a broad suite of resources to assist Tribunal members understand and perform their roles in accordance with clear standards that, in turn, are grounded in the principles of the Act. These resources include guidance on decision-making as part of a multidisciplinary team and procedures for incorporating practice reflection as an integral part of our work. This year, we have taken the logical and essential next step of developing a performance feedback framework that will provide all members with feedback about the approach they are taking to performing their role on the Tribunal. Work on this framework is well advanced and it will commence operating next year.

This year, the Tribunal also initiated a research project to explore and better understand our approach to decision-making; specifically, our role in setting the initial maximum duration of Treatment Orders. This aspect of the Act has had an immediate impact. Since commencement, the Tribunal has made a significant proportion of Treatment Orders with a duration that is less than half the maximum permitted under the Act. To analyse these decisions, the first phase of our research focuses on matters where the Tribunal makes a Treatment Order with a duration that is different to that proposed by a person's treating team. We want to quantify how frequently this happens and, where it does happen, identify the primary considerations or factors that underpin these decisions. Potential subsequent phases of this research will explore the Tribunal's reasoning in more detail, a person's subsequent treatment pathway and the perspective of consumers and treating teams on the Tribunal's approach.

Members of the Tribunal have also been exploring and reflecting on a complex question that arises from our functions: 'what is the nature and extent of the Tribunal's role or interest in treatment?' This may seem an unusual question – given the Tribunal makes Orders that compel people to have treatment for mental illness, it would be reasonable to reframe the question as 'how could the Tribunal not have an interest in treatment?'. But the issue is not straightforward. Historically, it was said of the former Mental Health Review Board that it was not part of the 'treatment space' occupied by mental health professionals and service providers. Arguably, this was not entirely accurate at the time and it is certainly incorrect in relation to the Tribunal exercising its primary decision-making functions in accordance with the principles set out in the Act.

Issues relating to treatment are fundamentally relevant to the Tribunal's decisions. But, at the same time, there are boundaries to the Tribunal's role in the examination of treatment-related matters. In particular the Tribunal does not make treatment decisions. However, hearings can and should be an opportunity for dialogue with and among consumers, carers and treating teams in which constructive inquiry about, clarification of and reflection on treatment options and issues can make a positive contribution to a person's progress towards less restrictive treatment and recovery. We will continue to reflect upon this aspect of our role, and promote clarity and understanding amongst participants in Tribunal hearings.

It is pleasing to confirm that several initiatives referred to or underway at the time of last year's annual report have now been completed. Tailored report templates for hearings relating to patients in Secure Extended Care Units are now in use. These are designed to elicit information about often complex patient histories, and just as importantly, about plans for future treatment. Similarly, an updated report template for ECT Order applications has been introduced and has significantly improved the provision of comprehensive, relevant information for ECT hearings. Our *Guide to Solution-Focused Hearings in the Mental Health Tribunal* now has two new chapters covering the particular needs of young people and older persons, and further additions are planned. Administrative changes have also been made to further streamline the listing of hearings, including case management strategies for complex matters.

To the members and staff of the Tribunal, I again say an enormous thank you. The achievements detailed in this report, whether it be the smooth operation of our regular business, or project-based initiatives designed to enhance the way we work, are the product of your hard work, skill and commitment. I also thank the members of our TAG for the candour, constructiveness and enthusiasm they bring to their role. I also acknowledge the support of the Department of Health and Human Services, particularly regarding the rollout of the electronic interface with health services, and in securing additional resources to support the operation of the Tribunal, particularly given its increasing workload over the past three years.

Shortly the Tribunal will commence preparation of a new three year strategic plan. We are committed to developing a challenging and ambitious plan that will see the Tribunal further contribute to the realisation of the Act's principles as its operation and application continues to evolve. The plan will reflect our ongoing commitment to improve how we operate, confirm our focus on enhancing the experience of consumers and carers, and ensure that we better meet the expectations of all those affected by or reliant upon our work.

Matthew Carroll
President

Shortly the Tribunal will commence preparation of a new three year strategic plan. We are committed to developing a challenging and ambitious plan that will see the Tribunal further contribute to the realisation of the Act's principles as its operation and application continues to evolve.

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 also determines:

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

Our vision

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

Our values

We strive to be:

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

Our goals

- **Participation**
  maximising opportunities for consumer and carer participation
- **Excellence in tribunal practice**
  embedding best practice in all aspects of our operation
- **Building excellence in mental health law**
  promoting transparency in decision making and contributing to the implementation and development of the 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 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.

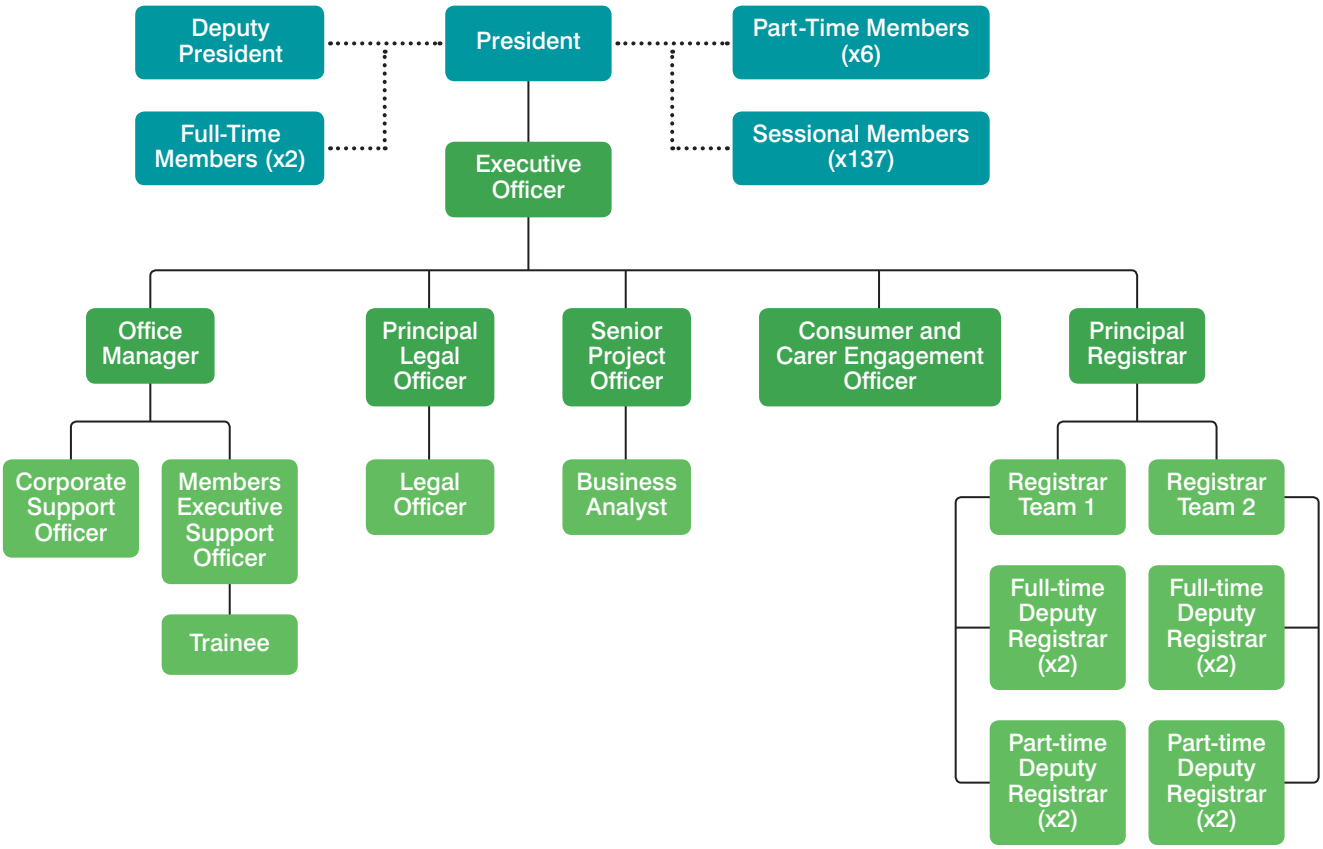
Membership changes during 2016-17

In April appointments to two senior roles in the Tribunal were finalised. Ms Troy Barty who was a Senior Legal Member was appointed Deputy President, and Mr Tony Lupton who was a sessional Legal Member was appointed a Senior Legal Member. In addition the President of the Tribunal, Mr Matthew Carroll, was reappointed for a further three year term.

This year two Psychiatrist Members retired from the Tribunal. Dr Sylvia Jones and Dr Frederick Stamp's resignations were accepted by the Governor in Council on 26 November 2016. Dr Jones and Dr Stamp both made a significant contribution to the work of both the Tribunal and the former Mental Health Review Board over a number of years.

Dr Jim Sparrow who was a Community Member of the Tribunal died suddenly on 15 September 2016. Dr Sparrow was first appointed as a Community Member of the Board on 7 September 2004 and in his role as a member and in a range of other voluntary roles was a committed advocate for the rights of people experiencing mental illness. Jim is greatly missed by everyone at the Tribunal.

Figure 1: *Mental Health Tribunal organisational chart as at 30 June 2017*



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

The Tribunal's core business is to perform its functions as set out in the *Mental Health Act 2014* (the Act), in accordance with the Tribunal's obligations as a public authority under the Victorian *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:

- a matter in relation to whether a Treatment Order should be made;
- an application to revoke a Temporary Treatment Order or Treatment Order;
- a matter in relation to an application involving the transfer of the treatment of a compulsory patient to another designated mental health service;
- an application to perform electroconvulsive treatment on a patient who does not have capacity to give informed consent;
- an application to perform electroconvulsive treatment on a person who is under the age of 18 years;
- an application to perform neurosurgery for mental illness;
- 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;
- an application by a security patient subject to a Secure Treatment Order to have the Order revoked;
- an application by a security patient in relation to a grant of leave of absence;
- an application by a security patient for a review of a direction to be taken to another designated mental health service;
- 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 (CSTO) is an Order made by a court to enable the person to be compulsorily taken to, and detained and treated in, a designated mental health service. A court may make a CSTO where the person is found guilty of an offence or pleads guilty to an offence and the relevant provisions specified in the sentencing legislation apply. The Order cannot exceed the period of imprisonment to which the person would have been sentenced had the Order not been made. Pursuant to s273 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives a security patient subject to a CSTO to determine whether the criteria for a CSTO apply to the security patient, and thereafter at 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 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives the security patient to determine whether the relevant criteria apply to the security patient, and thereafter at 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 determines whether ECT can be performed on a compulsory patient if they are considered to not have capacity to give informed consent to ECT, or for any person under the age of 18. If one or more of the criteria is not met, the Tribunal must refuse the Order. If the criteria are met, when making an Order the Tribunal must set the duration of the ECT Order 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 is 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 provide progress reports to the Chief Psychiatrist regarding the results of the neurosurgical procedure.

1.2 Administrative procedures

1.2.1 Scheduling of hearings

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

1.2.2 Location of hearings

The Tribunal conducts hearings at 57 venues on a weekly or fortnightly basis. Some divisions visit more than one 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.

In June the Tribunal's video network was upgraded to enable connections to remote satellite clinics that are part of some regional and rural 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 of hearings

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.

1.2.5 Interpreters

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

1.2.6 Information products

The Tribunal has developed a variety of information products for use by health services, consumers, carers and other interested parties. These information products are available on the Tribunal's website. The Tribunal's website also links to other relevant websites; for example, the 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 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, and be responsive to the needs of particular patients.
- 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, the membership has continued to work on the Members Development framework. The framework includes development activities and resources, and provides a coherent and consistent guide to all members whether they are new to the role or experienced. In 2016-17 the members commenced a program of observations to enable reflection on their own hearing approach and skills and significant work was also undertaken on the development of a formal feedback model.

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, with the assistance of health services, to arrange their own representation. Victoria Legal Aid and the Mental Health Legal Centre can provide free advice and legal representation at hearings. Statistics relating to legal representation are shown in Part Two.

1.3.4 Determinations and Orders

The Tribunal delivers its decision orally at the conclusion of the hearing and completes a written determination reflecting its decision. A copy of the determination is also provided to the consumer.

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 health service that is responsible for their treatment.

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

1.3.6 Statements of reasons

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

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

The Tribunal will also provide a statement of reasons where a party applies to VCAT for a review of a decision. Occasionally, the Tribunal may provide a statement 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* 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 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 225 requests for a statement of reasons. The Tribunal initiated eight 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 has decided to publish from time to time on its website a list categorising the published statements of reasons under the categories described above with links to the AustLII website.

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 available 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. The Tribunal also has a Practice Note on Observers at Mental Health Tribunal hearings which sets down a pre-hearing process for the making of requests to observe hearings 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.

In 2016-17 the Tribunal finalised a new practice note covering access to information prior to Tribunal hearings, including the process to be followed where a psychiatrist is applying to withhold documents. This Practice Note is described further in Part Three of this Report.

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 our website.

Figure 2: *Mental Health Tribunal KPIs*

1 Caseflow
- Matters determined as a proportion of matters requiring hearing
- Number of matters unable to be determined before expiry of order

2 Adjournments
- Number
- Reasons

3 Tribunal Orders
- Number of applications granted
  - category
  - duration
- Number of applications refused

4 ECT
- Number granted/refused
- Of applications granted
  - number of sessions approved
  - duration
- Elapsed time from receipt of ECT application to conducting hearing

5 Feedback and Participation
- Number of complaints/ feedback
- Source and type of complaint/feedback
- Attendance at hearings

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 90% of phone calls within 15 seconds 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. In 2016-17 the Tribunal responded to 94% of phone calls within 15 seconds and received one complaint regarding late response to an email.

1.4.3 Feedback

The Tribunal has a 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 via the website. The Tribunal's quarterly Key Performance Indicator reports (see Section 1.4.1 above) provide a summary of issues raised in complaints or feedback received by the Tribunal.

The Tribunal's Advisory Group (TAG) provides another avenue for the Tribunal to consult and receive feedback about its plans and activities. This year the Tribunal commenced work on 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 their experience of 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

This year the Tribunal and the Department collaborated on a significant project to develop and implement the electronic interface between public health services and the Tribunal. After a three month period of auditing and reporting by the Tribunal to support the implementation of systemic changes in public health services, the interface was rolled out on 28 November 2016. Since this date the Tribunal has been able to receive information about patients requiring hearings via this interface, reducing the workload on both health services and the Tribunal to manually process these records.

1.4.5 Stakeholder engagement

Legal representatives

Last year the Tribunal established a Legal Users Group that includes members of staff from VLA and the MHLC, and full and part time members and staff of the Tribunal.

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) also facilitates the provision of pro-bono legal representation to people on compulsory treatment orders. With this expansion in the providers of legal services in 2016-17 the Tribunal met quarterly with VLA and MHLC, twice by way of a Legal Users Group meeting, and in the alternate quarters, liaison meetings involving senior representatives from each organisation.

Tribunal Advisory Group

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

Health services

The Tribunal's full and part time members each have responsibility for a number of health services for which they act as the liaison member and where they sit on hearings on a regular basis. This year the Tribunal has also enlisted the assistance of two sessional members as liaison members to assist with coverage of these duties while we recruited to fill member vacancies. 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
- Health Complaints Commissioner
- Office of the Chief Psychiatrist
- TANDEM
- VMIAC

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 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 Two:
Hearing statistics for 2016-17

Key statistics at a glance*

	2016–17 Number	2015–16 Number	2014–15 Number
Hearings listed **	**12,767**	12,185	10,308
Hearings conducted Hearings with determination made Hearings adjourned	**7,818** **7,198** **620**	7,462 6,871 591	6,615 6,182 433
Treatment Orders made	**5,925**	5,603	4,912
TO / TTOs Revoked	**371**	358	417
ECT Orders made	**590**	620	550
ECT applications refused	**100**	86	68
NMI hearings conducted	**6**	2	3
Statements of Reasons requested	**225**	243	229
Applications to VCAT	**33**	20	24

Attendance at hearings***

	2016–17 Number	2015–16 Number	2014–15 Number
Patients attended hearing	**4,699**	3,984	3,749
Family attended hearing	**1,310**	1,083	1,092
Carers attended hearing	**418**	361	282
Nominated persons attended hearing	**180**	308	202
Patients with legal representation at hearing	**1,197**	1,048	1,101
Interpreters at hearing	**289**	236	207

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

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

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

**** Figures for attendance in 2014-15 and 2015-16 may have been varied from figures published in previous Annual Reports due to improved reporting methodology.*

2.1 Summary of determinations made by the Tribunal

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 1: *Determinations at Tribunal hearings*

Type of hearing	2016–17	2015–16	2014–15
Hearings regarding a treatment order			
Community Treatment Orders made	**3,423**	3,121	2,588
Inpatient Treatment Orders made	**2,502**	2,482	2,324
Temporary Treatment Orders / Treatment Orders revoked	**371**	358	417
Hearings struck out	**67**	65	62
No jurisdiction	**5**	11	21
Total	***6,368***	*6,037*	*5,412*
Urgent applications for electroconvulsive treatment			
ECT Orders made	**351**	353	280
ECT applications refused	**54**	44	23
No jurisdiction	**0**	0	3
Total	***405***	*397*	*306*
Standard applications for electroconvulsive treatment			
ECT Orders made	**237**	267	270
ECT applications refused	**46**	42	45
No jurisdiction	**0**	0	0
Total	***283***	*309*	*315*
Applications for electroconvulsive treatment for voluntary patients under 18 years of age			
ECT Orders made	**2**	4	0
ECT applications refused	**1**	0	0
Total	***3***	*4*	*0*
Hearings for a Security Patient			
Patient remained a Security Patient	**72**	76	98
Patient discharged as Security Patient	**6**	2	4
Total	***78***	*78*	*102*
Applications by security patient regarding leave			
Applications refused	**0**	1	0
Total	***0***	*1*	*0*
Applications to deny access to documents			
Applications granted	**39**	35	23
Applications refused	**10**	2	6
Applications withdrawn	**0**	1	0
Total	***49***	*38*	*29*
Applications to stop transfer to another service			
Applications granted	**0**	0	4
Applications refused	**4**	4	5
Applications struck out	**2**	0	2
No jurisdiction	**1**	1	3
Total	***7***	*5*	*14*
Applications to transfer a patient interstate			
Applications granted	**1**	0	1
Total	***1***	*0*	*1*
Applications for neurosurgery for mental illness			
Applications granted	**5**	2	3
Applications refused	**1**	0	0
Total	***6***	*2*	*3*
Grand total of determinations made by the Tribunal	***7,198***	*6,871*	*6,182*

2.2 Treatment Orders

2.2.1 Outcomes of hearings regarding Treatment Orders

In 2016-17, the Tribunal made a total of 5,925 Treatment Orders (TOs) and revoked 371 Temporary Treatment Orders (TTOs) or TOs. There were a small number of matters where the Tribunal found it did not have jurisdiction to conduct a hearing (five) and 67 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 2: *Determinations regarding Treatment Orders*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**3,423**	**54%**	3,121	52%	2,588	48%
Inpatient Treatment Orders made	**2,502**	**40%**	2,482	42%	2,324	44%
Temporary Treatment Orders / Treatment Orders revoked	**371**	**6%**	358	6%	417	8%
Total Orders made or revoked	**6,296**	**100%**	5,961	100%	5,329	100%

Figure 3: *Determinations regarding Treatment Orders in 2016-17*

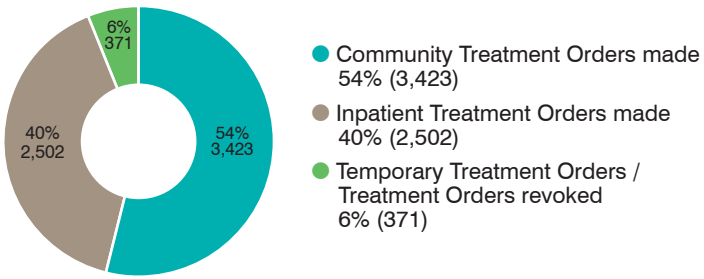


Table 3: *Duration of Community Treatment Orders made*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
1–13 weeks	**464**	**13%**	478	15%	403	16%
14–26 weeks	**1,331**	**39%**	1,193	38%	923	36%
27–39 weeks	**61**	**2%**	51	2%	62	2%
40–52 weeks	**1,567**	**46%**	1,399	45%	1,200	46%
Total	**3,423**	**100%**	3,121	100%	2,588	100%

Figure 4: *Duration of Community Treatment Orders made in 2016-17*

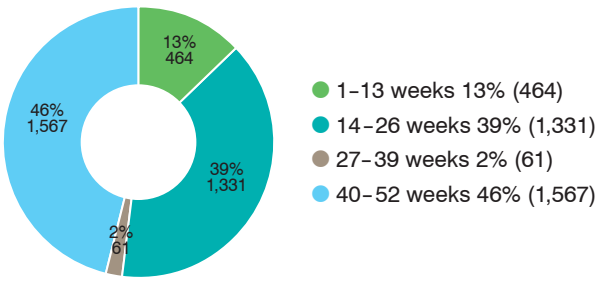
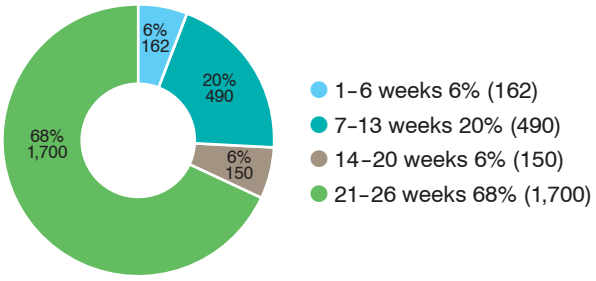


Table 4: *Duration of Inpatient Treatment Orders made*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
1–6 weeks	**162**	**6%**	164	7%	233	10%
7–13 weeks	**490**	**20%**	546	22%	565	24%
14–20 weeks	**150**	**6%**	168	7%	157	7%
21–26 weeks	**1,700**	**68%**	1,604	65%	1,369	59%
Total	**2,502**	**100%**	2,482	100%	2,324	100%

Figure 5: *Duration of Inpatient Treatment Orders made in 2016-17*



2.2.2 Treatment Order hearing outcomes by initiating case type

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

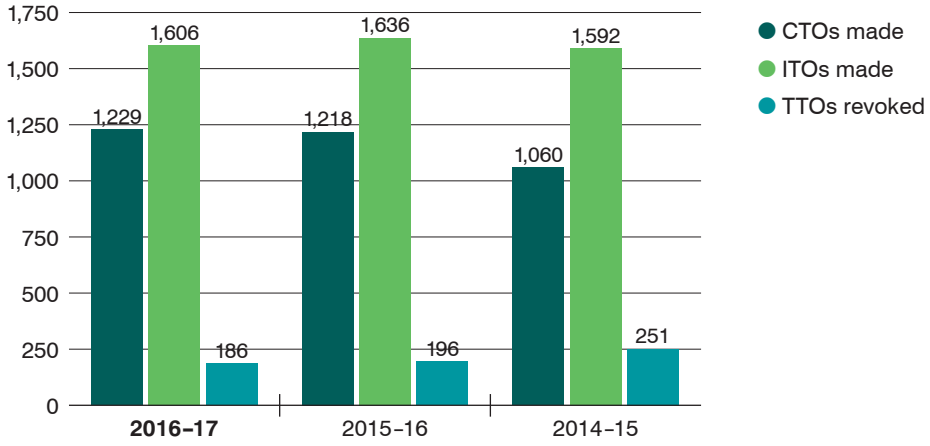
28 day hearings

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

Table 5: *Outcomes of 28 day hearings*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**1,229**	**41%**	1,218	40%	1,060	36%
Inpatient Treatment Orders made	**1,606**	**53%**	1,636	54%	1,592	55%
Temporary Treatment Orders revoked	**186**	**6%**	196	6%	251	9%
Total Treatment Orders made or revoked	**3,021**	**100%**	3,050	100%	2,903	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 were as follows:

Table 6: *Reasons the Tribunal revoked Temporary Treatment Orders in 28 day hearings*

	2016–17	2015–16	2014–15
Treatment was able to be provided in a less restrictive manner	**59%**	57%	56%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**16%**	18%	18%
Immediate treatment was not able to be provided	**14%**	19%	18%
The person did not have a mental illness	**11%**	6%	8%
Total	**100%**	100%	100%

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 seven 28 day hearings.

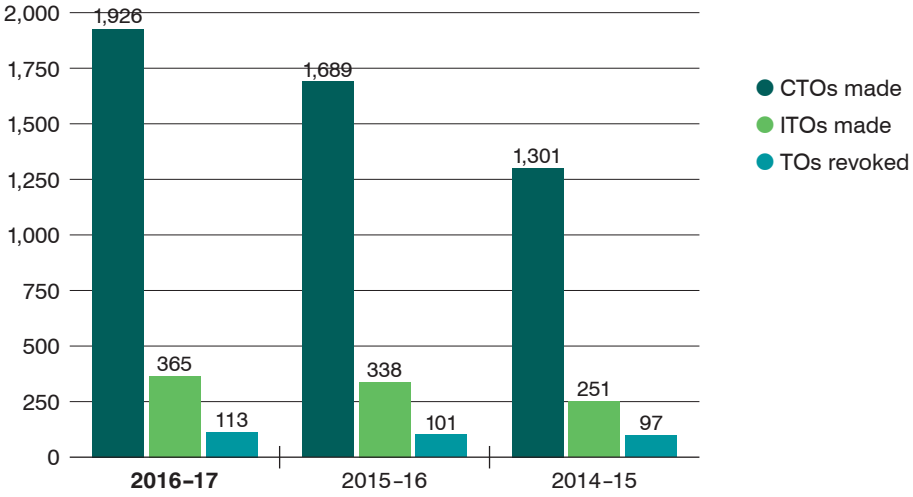
Applications for a Treatment Order by the authorised psychiatrist

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

Table 7: *Outcomes of authorised psychiatrist application hearings*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**1,926**	**80%**	1,689	79%	1,301	79%
Inpatient Treatment Orders made	**365**	**15%**	338	16%	251	15%
Treatment Orders revoked	**113**	**5%**	101	5%	97	6%
Total Treatment Orders made or revoked	**2,404**	**100%**	2,128	100%	1,649	100%

Figure 7: *Outcomes of authorised psychiatrist application hearings*



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:

Table 8: *Reasons the Tribunal revoked Treatment Orders in authorised psychiatrist application hearings*

	2016–17	2015–16	2014–15
Treatment was able to be provided in a less restrictive manner	**62%**	60%	57%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**18%**	18%	18%
Immediate treatment was not able to be provided	**13%**	12%	14%
The person did not have a mental illness	**7%**	10%	11%
Total	**100%**	100%	100%

In relation to five 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.

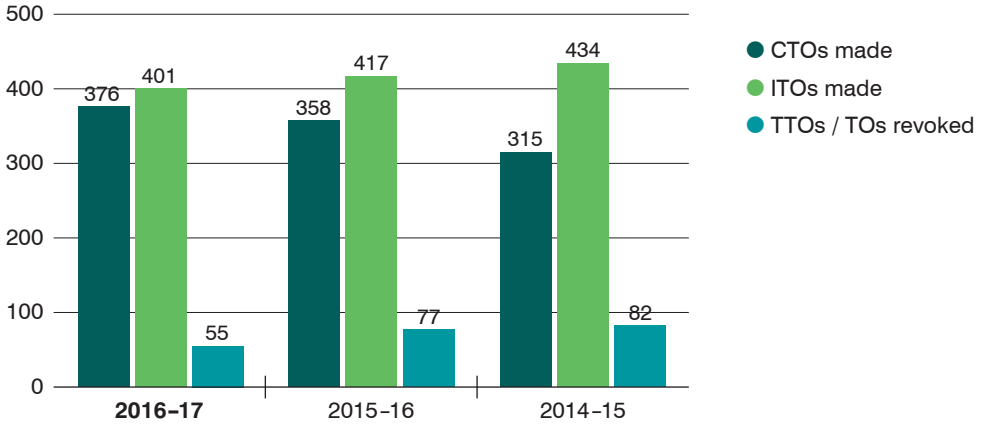
Applications for revocation by or on behalf of a patient

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

Table 9: *Outcomes of revocation hearings*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**376**	**45%**	358	42%	315	38%
Inpatient Treatment Orders made	**401**	**48%**	417	49%	434	52%
Temporary Treatment Orders / Treatment Orders revoked	**55**	**7%**	77	9%	82	10%
Total Treatment Orders made or revoked	**832**	**100%**	852	100%	831	100%

Figure 8: *Outcomes of revocation hearings*



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

Table 10: *Reasons the Tribunal revoked Temporary Treatment Orders / Treatment Orders in patient application hearings*

	2016–17	2015–16	2014–15
Treatment was able to be provided in a less restrictive manner	**46%**	53%	45%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**25%**	23%	28%
Immediate treatment was not able to be provided	**14%**	17%	16%
The person did not have a mental illness	**15%**	7%	11%
Total	**100%**	100%	100%

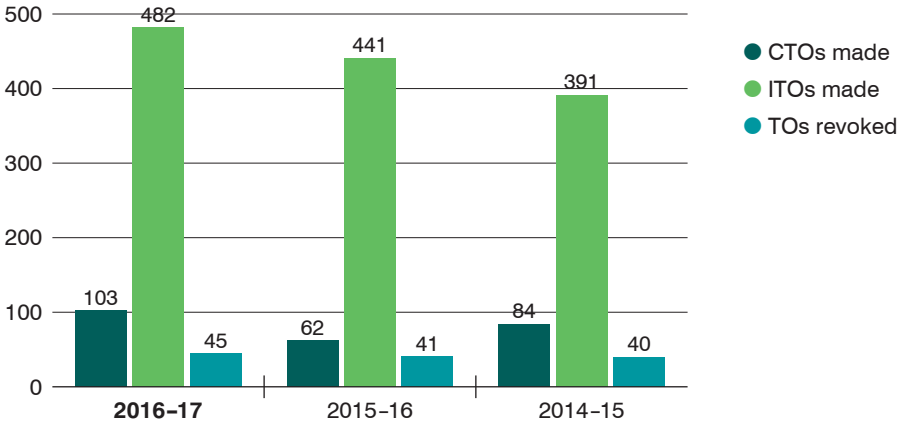
Variation hearings

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 11: *Outcomes of variation hearings*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**103**	**16%**	62	11%	84	16%
Inpatient Treatment Orders made	**482**	**77%**	441	81%	391	76%
Treatment Orders revoked	**45**	**7%**	41	8%	40	8%
Total Treatment Orders made or revoked	**630**	**100%**	544	100%	515	100%

Figure 9: *Outcomes of variation hearings*



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

Table 12: *Reasons the Tribunal revoked Treatment Orders in variation hearings*

	2016–17	2015–16	2014–15
Treatment was able to be provided in a less restrictive manner	**9%**	22%	30%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**5%**	7%	7%
Immediate treatment was not able to be provided	**86%**	61%	60%
The person did not have a mental illness	**0%**	10%	3%
Total	**100%**	100%	100%

2.3 ECT Orders

2.3.1 Outcomes of applications for an ECT Order relating to adult, compulsory patients

In 2016-17 the MHT heard a total of 688 applications for an ECT Order. The following graphs provide details of the ECT Orders made and refused, the duration of Orders, number of ECT treatments authorised, and timeframes for the hearing of applications.

Table 13: *Determinations regarding ECT applications (adult, compulsory patients)*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
ECT Orders made	**588**	**85%**	620	88%	550	89%
ECT applications refused	**100**	**15%**	86	12%	68	11%
Total ECT Orders made or applications refused	**688**	**100%**	706	100%	618	100%

Table 14: *Reasons applications for an ECT Order were refused (adult, compulsory patients)*

	2016–17	2015–16	2014–15
Treatment was able to be provided in a less restrictive manner	**53%**	56%	61%
Patient had the capacity to give informed consent	**41%**	40%	34%
Tribunal was provided with insufficient information to make a decision	**6%**	4%	5%
Total	**100%**	100%	100%

Figure 10: *Determinations regarding ECT applications (adult, compulsory patients) in 2016-17*

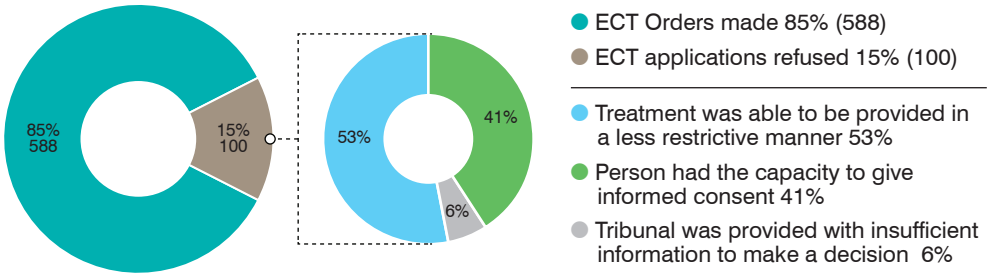


Table 15: *Duration of ECT Orders (adult, compulsory patients)*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
1–6 weeks	**308**	**52%**	338	55%	268	49%
7–13 weeks	**104**	**18%**	131	21%	135	25%
14–20 weeks	**29**	**5%**	19	3%	14	2%
21–26 weeks	**147**	**25%**	132	21%	133	24%
Total	**588**	**100%**	620	100%	550	100%

Figure 11: *Duration of ECT Orders (adult, compulsory patients) in 2016-17*

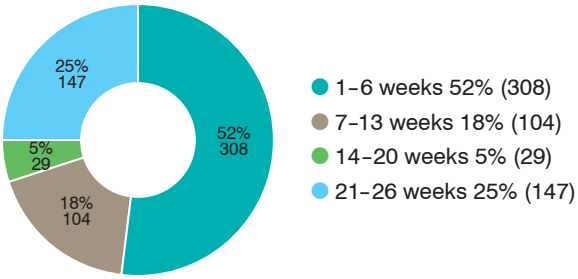
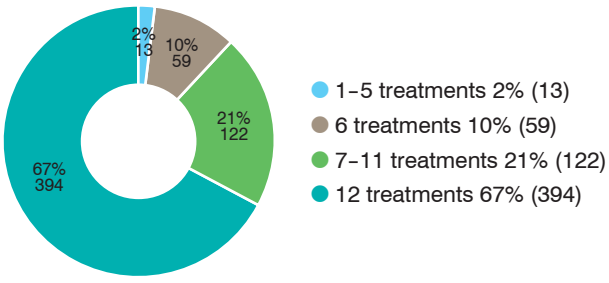


Table 16: *Number of ECT treatments authorised (adult, compulsory patients)*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
1–5 treatments	**13**	**2%**	29	5%	18	3%
6 treatments	**59**	**10%**	75	12%	61	11%
7–11 treatments	**122**	**21%**	111	18%	59	11%
12 treatments	**394**	**67%**	405	65%	412	75%
Total	**588**	**100%**	620	100%	550	100%

Figure 12: *Number of ECT treatments authorised (adult, compulsory patients) in 2016-17*



2.3.2 Urgent ECT applications

The Tribunal classifies ECT applications as either standard or urgent based on how soon the treating team wants the hearing to be listed. Urgent ECT applications are those requested to be conducted within two days of receipt. All ECT hearings must be conducted within five business days of receipt.

Pursuant to s95(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:

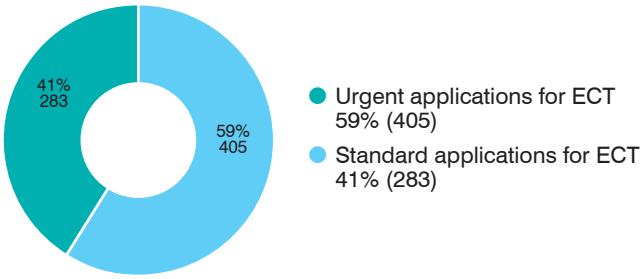
- to save the life of the patient; or
- to prevent serious damage to the heath of a patient; or
- to prevent the patient from suffering or continuing to suffer significant pain or distress.

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

Table 17: *Proportion of applications for ECT Order which were urgent*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Urgent applications for ECT	**405**	**59%**	397	56%	306	49%
Standard applications for ECT	**283**	**41%**	309	44%	315	51%
Total ECT applications	**688**	**100%**	706	100%	621	100%

Figure 13: *Proportion of applications for ECT Orders which were urgent in 2016-17*



Urgent after-hours ECT applications

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

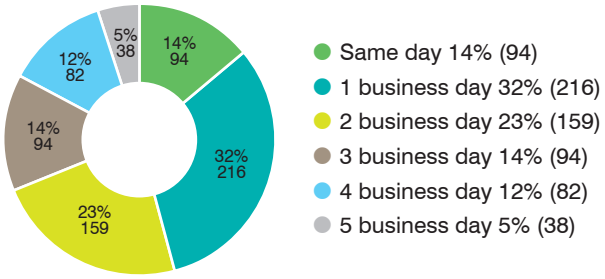
In 2016-17, the Tribunal heard five urgent after-hours ECT applications. All of the applications were granted.

2.3.3 **Elapsed time from receipt of ECT applications to hearing**

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

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Same day	**94**	**14%**	140	20%	126	20%
1 business day	**216**	**32%**	215	31%	174	28%
2 business days	**159**	**23%**	151	21%	134	22%
3 business days	**94**	**14%**	90	13%	87	14%
4 business days	**82**	**12%**	72	10%	76	12%
5 business days	**38**	**5%**	35	5%	23	4%
Total	**683**	**100%**	703	100%	620	100%

Figure 14: *Elapsed time from receipt of ECT applications to hearing in 2016-17*



2.3.4 **ECT Order applications related to a young person under 18 years**

Compulsory patients

During 2016-17, no applications for an ECT Order were received relating to a compulsory patient under 18 years of age.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2016-17, three applications for an ECT Order related to a young person being treated as a voluntary patient, in each matter the young person was 17 years old. Two of the applications were granted and one was refused.

2.4 Neurosurgery for mental illness

During 2016-2017, the Tribunal received four applications to perform neurosurgery for mental illness (NMI) and finalised two applications received in the previous financial year, as shown in the table below.

Table 20: *Number and outcomes of applications to perform NMI*

Applications	Applicant health service	Diagnosis	Proposed Treatment	Location of patient	Hearing outcome
Pending at end of 2015-2016 financial year	Monash Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	Victoria	Granted
Pending at end of 2015-2016 financial year	Monash Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	New South Wales	Granted
1	Monash Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	Queensland	Granted
2	Monash Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	Australian Capital Territory	Granted
3	Monash Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	Queensland	Granted
4	St Vincent's Hospital	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Refused

2.5 Security patients

During 2016-17, the Tribunal made 78 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

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

	2016–17	2015–16	2014–15
	No.	No.	No.
Hearings for a security patient			
28 day review			
Remain a security patient	**59**	61	82
Discharge as a security patient	**6**	1	2
Six month review			
Remain a security patient	**9**	13	11
Discharge as a security patient	**0**	1	0
Application for revocation by or on behalf of the patient			
Remain a security patient	**4**	4	8
Discharge as a security patient	**0**	0	2
Total hearings for a security patient	**78**	80	105
Application by a security patient regarding leave			
Applications granted	**0**	0	0
Applications refused	**0**	1	0
Total applications by a security patient regarding leave	**0**	1	0

2.6 Applications to review the transfer of patient to another service

During 2016-17, seven applications to review the transfer of a patient to another health service were received by the Tribunal.

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

	2016–17	2015–16	2014–15
Applications granted	0	0	4
Applications refused	4	4	5
Applications struck out	2	0	2
No jurisdiction	1	1	3
Total	7	5	14

2.7 Applications to deny access to documents

During 2016-17, the Tribunal received 49 applications to deny access to documents.

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

	2016–17	2015–16	2014–15
Applications granted	39	35	23
Applications refused	10	2	6
Applications withdrawn	0	1	0
Total	49	38	29

2.8 Applications to transfer a patient interstate

During 2016-17 there was one application received by the Tribunal to transfer a patient interstate.

Table 24: *Number and outcomes of applications to transfer a patient interstate*

	2016–17	2015–16	2014–15
Applications granted	1	0	1
Applications refused	0	0	0
Applications struck out	0	0	0
No jurisdiction	0	0	0
Total	1	0	1

2.9 Applications for review by VCAT

During the year, 33 applications were made to VCAT for a review of a Tribunal decision.

Table 25: *Applications to VCAT and their status*

	2016–17	2015–16	2014–15
Applications made	33	20	24
Applications withdrawn	14	12	12
Applications struck out	2	1	2
Applications dismissed	1	0	1
Hearings vacated	0	1	0
Applications proceeded to full hearing and determination	9	6	7
Set aside by consent	1	0	0
Applications pending at 30 June	6	0	2

Table 26: *Outcomes of applications determined by VCAT*

	2016–17	2015–16	2014–15
Decisions affirmed	6	5	5
Decisions varied	1	0	2
Decisions set aside and another decision made in substitution	1	0	0
Orders revoked	1	1	0

2.10 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 still within 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 are collated under three categories: procedural fairness (including to enable participation of the patient or other relevant persons in the hearing), to enable legal representation, and where the health service was not ready to proceed with the hearing.

Table 27: *Hearings adjourned*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Hearings adjourned without Order extended	**152**	**25%**	173	29%	220	51%
Hearings adjourned with Order extended	**468**	**75%**	418	71%	213	49%
Total hearings adjourned	**620**	**100%**	591	100%	433	100%
Total hearings adjourned as a percentage of total hearings conducted	**8%**		8%		7%	

Figure 15: *Hearings adjourned in 2016-17*

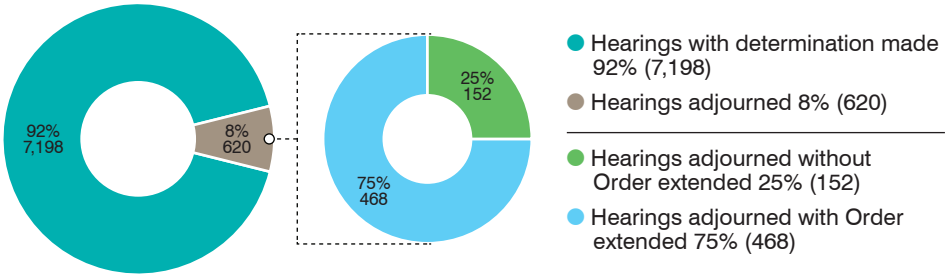
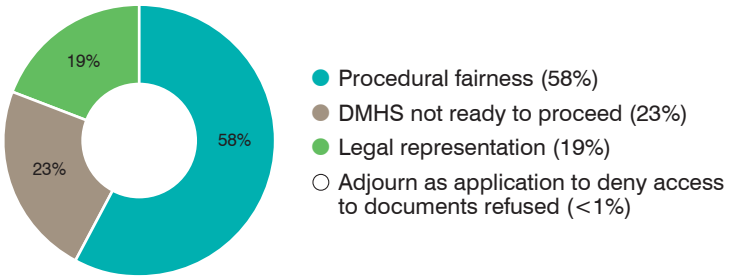


Table 28: *Reasons for adjournments with extension of Order*

	2016–17	2015–16	2014–15
Procedural fairness	**58%**	54%	64%
DMHS not ready to proceed	**23%**	29%	26%
Legal representation	**19%**	17%	10%
Adjourn as application to deny access to documents refused	**<1%**[1]	0%	0%
Total	**100%**	100%	100%

1. This year the Tribunal adjourned one hearing and extended the Treatment Order pursuant to s191(4)(b), to allow the patient to have access to documents following the refusal of an application to deny access to those documents.

Figure 16: *Reasons for adjournments with extension of Order in 2016-17*



2.11 Hearings conducted by mode

As discussed in Part One, while the Tribunal prefers to conduct hearings in-person, it is not always possible to do so. In 2016-17, less than one quarter of hearings were conducted via video conferencing which was a decrease from the previous two years.

Table 29: *Hearings conducted by mode*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
In-person	**5,966**	**76%**	5,502	74%	4,707	71%
Video conference	**1,835**	**24%**	1,956	26%	1,908	29%
Teleconference	**25***	**<1%**	13	<1%	–**	–**
Totals hearings conducted#	**7,826**	**100%**	7,471	100%	6,615	100%

* *Five of these matters were urgent ECT hearings conducted after-hours. Seven of these matters were conducted when the video-conference functionality ceased to work due to a connectivity issue or equipment failure.*

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

\# *On some occasions, both video and teleconference facilities were used to enable parties to participate in hearings.*

2.12 Attendance and legal representation at hearings

Part Three of the Annual Report highlights the Tribunal's commitment to promoting the participation of patients and the people who support them in hearings. 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 30: *Number and percentage of hearings with the patients and support people in attendance*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Patient	**4,699**	**61%**	3,978	54%	3,740	57%
Carer#	**418**	**5%**	360	5%	1,370	22%
Family member#	**1,310**	**17%**	1,080	16%		
Nominated person	**180**	**2%**	308	4%	202	3%
Legal representative	**1,197**	**15%**	1,047	15%	1,187	19%
Interpreter	**289**	**4%**	236	3%	205	3%
Total hearings conducted*	**7,818**	**100%**	–	–	–	–
Total hearings determined*	**–**	**–**	6,871	100%	6,182	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.*

* *In July 2016, the Tribunal commenced recording attendance and diagnosis statistics at adjourned hearings. As this information was not collected in 2014-15 or 2015-16, a comparison of total attendance between 2016-17 and prior years is not possible.*

Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the number of patients who received legal representation by provider in 2016-17.

Table 31: *Legal representation at hearings*

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Victoria Legal Aid	**1,058**	**14%**	920	13%	1,101*	18%
Mental Health Legal Centre	**80**	**1%**	73	1%	40	1%
Private Lawyer	**39**	**<1%**	36	1%	29	< 1%
Other Community Legal Centre	**20**	**<1%**	18	<1%	17	< 1%
Total legal representation	**1,197**	**15%**	1,047	15%	1,187	19%
Total hearings conducted	**7,818**	**100%**	–	–	–	–
Total hearings determined	**–**	**–**	6,871	100%	6,182	100%

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

2.13 **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 the indicative percentage of the primary diagnosis of patients who had Tribunal hearings in 2016-17.

Table 32: *Primary diagnoses of patients who had Tribunal hearings*

	2016–17	2015–16	2014–15
Schizophrenia	**47%**	47%	50%
Schizoaffective disorder	**21%**	26%	21%
Bipolar disorder	**10%**	11%	12%
Depressive disorders	**4%**	3%	4%
Delusional disorder	**2%**	2%	2%
Dementia	**1%**	1%	1%
No diagnosis recorded	**5%**	1%	1%
Other organic disorders	**0%**	0%	1%
Eating disorders	**1%**	1%	1%
Other	**9%**	8%	7%
Total	**100%**	100%	100%

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 being conducted within time prior to conducting the hearing.

If 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 2016-17, there were four matters where a hearing was not conducted before a patient's Order expired because of a Tribunal error. In a further three matters, a hearing was not conducted because of an error on the part of the treating service.

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 2016-17, periodic audits identified five matters where the hearing proceeded despite the patient's Order having ended due to an accidental or unintentional miscalculation of time.

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 2016-17, thirteen variation hearings were conducted more than 28 days after the variation of the Order. In seven 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 three matters, the cause was Tribunal error.

Additionally, there were two ECT hearings conducted out of time because of Tribunal error.

Illustration 1

Determining whether the person has mental illness

The first treatment criterion requires the Tribunal to determine whether a person has mental illness. The *Mental Health Act 2014* defines mental illness as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

Under the Act, certain things cannot be the sole basis for concluding that a person has a mental illness. One of these exclusions is drug use and the Tribunal has had to consider the implications of this exclusion in a number of hearings.

The increasing use of ice and other drugs in the community means that people suffering a drug-induced psychosis often present to hospital emergency departments and are subsequently admitted to mental health wards. When symptoms stemming from drug use is the sole reason for a patient's compulsory admission, the Tribunal must decide whether the person meets the definition of mental illness under the Act. Although the Act specifically states a person is not to be considered to have mental illness only because they use drugs, the Act also states it does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness.

In *XUV* [2016] VMHT 99, the patient had received treatment for mental illness in the past but had no contact with mental health services for 10 years until the lead up to the hearing, whereupon he had had three admissions in the space of three months. XUV's lawyer conceded that XUV was suffering from mental illness at the time of his admissions; however, at the time of the hearing the psychosis had resolved and he no longer had mental illness. The treating team said XUV had a significant disturbance of thought and perception. During his admissions, XUV was paranoid and experienced delusions. The treating team said that XUV had experienced these symptoms over a prolonged period of time – for more than a year – and this had escalated over the last few months in the context of frequent and escalating drug use.

The Tribunal noted the provisions regarding drug use set out above and considered how these two provisions worked together under the Act. The Tribunal said the combined effect of these provisions is that drug use by itself is not sufficient to satisfy the first criterion, but the symptoms or effects of drug use can be an indication that a person has mental illness and therefore meets the criterion. This allows for compulsory treatment of a person who is experiencing serious physiological, biochemical or psychological effects of using drugs whether those symptoms are temporary or more lasting (and of course only if the other criteria are met).

In XUV's case, he had experienced psychotic symptoms over a period of time and his symptoms had escalated in the context of increased use of methamphetamine. The Tribunal accepted the evidence about XUV's reported behaviours, which demonstrated significant degrees of paranoia and persecutory delusions. His methamphetamine use precipitated or exacerbated his symptoms. When using drugs, XUV experienced seriously disturbed thinking with perceptual disturbances. The Tribunal accepted the evidence and concluded that XUV had a medical condition characterised by a significant disturbance of thought and perception.

In *KGJ* [2016] VMHT 102, a central question that emerged was whether KGJ's history of psychiatric admissions were a consequence of an underlying mental illness or, alternatively, whether they were each discrete episodes of drug-induced psychosis with complete inter-episode recovery. KGJ was admitted to hospital several times in the year preceding the Tribunal hearing. Prior to each admission, he experienced paranoia, agitation, aggression and delusions. During those admissions, the treating team had been unsure whether KGJ was suffering from drug-induced psychosis or schizophrenia.

At the hearing, the treating team said KGJ's diagnosis had evolved over time. Whilst initially thought to be discrete episodes of drug-induced psychosis, they now felt that his clinical picture was more consistent with an underlying schizophrenia exacerbated by his drug use. The doctor noted that although KGJ's acute psychotic symptoms settled between each admission, he had poor inter-episode recovery. His gradual social decline and increasing depression leading up to his first admission was also suggestive of an early sign of schizophrenia. The treating team noted that it had only been since the commencement of regular depot medication that KGJ had been able to remain out of hospital for a sustained period. In the months leading up to the hearing, and while receiving medication, there had been considerable improvement in KGJ's stability, which the treating team attributed to the depot medication having a positive effect on his mental state.

The Tribunal agreed that with the passage of time and the gathering of further collateral history, the picture that emerged was more in keeping with an underlying medical condition, the positive symptoms of which had failed to fully resolve between episodes until the commencement of regular depot medication several months ago. The Tribunal found KGJ had a medical condition characterised by a significant disturbance of thought and perception.

These two cases are in contrast to *FSY* [2016] VMHT 93 in which the Tribunal was not satisfied that the patient had mental illness. FSY had used drugs for almost 10 years. He had been in contact with mental health services for about two years when he was admitted to hospital suffering psychotic symptoms in the context of drug use. He was discharged home after 10 days, however FSY continued to heavily use drugs and there were several further admissions to hospital. On each occasion he had made a rapid and full recovery with treatment while abstaining from drugs, but on discharge from hospital, he had not engaged with the treating team, resumed his drug use and not taken medication. The treating team said a diagnosis of schizophrenia was supported by FSY's strong family history of the illness, the length of his stays in hospital increased with each admission, his ongoing residual symptoms, and because he had not stayed well except when receiving treatment subject to a Treatment Order. FSY's lawyer submitted that the evidence of schizophrenia was inconclusive, and that, because of FSY's very heavy past drug use, there had been little opportunity to assess whether his psychotic episodes were solely drug-induced or attributable also to an underlying mental illness and this could not be done while FSY remained on medication.

The Tribunal carefully considered the evidence presented to it and was unable to conclude on the balance of probabilities that FSY was suffering from an underlying mental illness characterised by a significant disturbance of thought, mood, memory or perception. Although section 4(3) of the Act not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drugs or consuming alcohol from being regarded as an indication that a person has a mental illness, the Tribunal noted the onus is on the treating team to satisfy the Tribunal that there was such an indication in this case. While accepting that it was highly likely that FSY would suffer another serious psychotic episode if he were to use methamphetamine again, there was no conclusive evidence that ceasing anti-psychotic medication would cause such an episode.

Illustration 2

Considering whether the person will suffer serious deterioration in their mental health if they don't receive immediate treatment

The second treatment criterion requires the Tribunal to decide whether a person needs immediate treatment to prevent serious deterioration in their mental health or physical health or to prevent serious harm to themselves or to another person. This year the Tribunal explored the nuances of serious deterioration in a person's mental health. The *Mental Health Act 2014* does not define the term 'serious deterioration'.

In *NVI* [2016] VMHT 104, the patient was diagnosed with delusional disorder and had had three hospital admissions in three years. NVI was receiving depot medication at the time of hearing. He said there was no risk of serious deterioration in his mental health if he stopped medication because his thoughts had not changed despite the depot and when he last stopped depot it had taken months for him to be re-admitted to hospital. NVI's treating team said that when he had stopped the depot, he experienced symptoms of grandiosity, religiosity, paranoia, disorganised thoughts, impaired judgment and aggression and needed to be hospitalised. NVI had improved after receiving depot again.

NVI's lawyer said that NVI would not suffer serious deterioration without immediate treatment because there was a period of many months between NVI stopping treatment and his eventual need for hospitalisation. However, the Tribunal determined that this criterion did not require evidence of a rapid deterioration in the person's mental health – this criterion required consideration of the *need* for immediate treatment and the *degree* of deterioration, rather than whether there was immediate deterioration in the absence of treatment. It was incorrect to consider that the criterion required an *immediate* or rapid deterioration after stopping treatment. The Tribunal was satisfied that when he stopped treatment, NVI's mental state deteriorated resulting in distressing and disturbed thinking that required a further admission to hospital, and that the deterioration in his mental state was serious.

In *AYT* [2016] VMHT 62, the Tribunal again examined the correct test and considered what effect the immediate treatment must have on the person's mental health. AYT had an extensive psychiatric history. At the time of the hearing, she had not been hospitalised for more than a year. Despite treatment, she continued to misidentify her mother and also express delusional ideas. However, it was clear that the intensity of AYT's symptoms had significantly decreased for an extended period of time.

AYT's lawyer said the threshold of serious deterioration was not met because AYT had suffered acute relapses while she was receiving medication and AYT's symptoms persisted even though she was receiving medication. AYT's doctor agreed she was continuing to experience symptoms and she had also experienced more severe symptoms while being treated; this indicated AYT had a form of treatment resistant schizophrenia. The doctor said that this meant the need for immediate treatment was greater because in the absence of treatment AYT would be likely to relapse more quickly and seriously.

The Tribunal found that this criterion does not require the treating team to show treatment will lead to full remission; reducing the intensity and/or impact of symptoms is sufficient. AYT had a long history of severe symptoms of mental illness that had caused significant disruption to her life and serious harm to others. However, it was a significant and positive development that AYT had had more than a year of relative stability, and while symptoms continued, her mental health was considerably improved. The Tribunal gave considerable weight to this positive change. However, the Tribunal agreed that viewed longitudinally, and taking into account the persistence of some symptoms, AYT's mental health (and as a consequence her broader circumstances) could regress seriously if treatment did not continue.

In *XTB* [2016] VMHT 97, the patient had been receiving treatment from a private psychiatrist for schizophrenia for many years. He stopped seeing his psychiatrist and attended his general practitioner to receive medication, however ceased his depot a year prior to the hearing. XTB's doctor said that on admission, XTB had showed acute signs of psychosis and that these symptoms appeared to be resolving with medication.

At the hearing, it was clear XTB's mental state had improved and he was able to offer rational explanations for his recent behaviour. XTB also described a reasonable future plan for treatment. He intended to find an appropriate general practitioner to manage his treatment in the future and was prepared to continue with oral medication and would consider depot medication but did not feel it made much difference. XTB's doctor said the main concern was the risk that XTB would deteriorate in his functioning if he discontinued treatment.

The Tribunal accepted XTB functions better when he is on medication to treat his mental illness. However, whilst there is a risk of deterioration in XTB's mental health without treatment, the Tribunal was not satisfied that this was sufficiently serious to satisfy the threshold of *serious deterioration* in this criterion. XTB had continued to work, conduct relationships and find accommodation over the 18 months when he was not on medication. The Tribunal also noted that XTB had functioned for many years as a voluntary patient and only had one previous admission many years ago. The Tribunal took into account that XTB said he was prepared to continue with oral medication and was intending to find a suitable general practitioner.

Illustration 3

Determining whether the person can be treated less restrictively

In both Treatment Order and ECT hearings, the Tribunal is required to consider whether there is a less restrictive way for the person to be treated. The *Mental Health Act 2014* does not define 'less restrictive treatment'. The below decisions demonstrate the types of matters the Tribunal takes into account when considering whether there is a less restrictive type of treatment available.

When deciding whether a person requires compulsory treatment, the last treatment criterion asks the Tribunal to decide whether there are less restrictive means reasonably available to enable the person to receive the immediate treatment, that is, does the person need to be treated under a compulsory Treatment Order?

In *HPH* [2016] VMHT 78, the patient was diagnosed with substance-induced psychosis. HPH recognised he was suffering from anxiety. He said he would work with the treating team and contact them for support and for cognitive behavioural therapy. He wanted to continue with medication at the current dose because he found it helpful. HPH wanted ownership of his recovery and since he had left hospital, the treating team had not been monitoring or supervising his medication. HPH told the Tribunal that he was keen to recommence work and had a job interview lined up. He was concerned that if he was working, it would not be possible to make appointments at the service as he would not be able to take time off; he wanted to transfer his care to his general practitioner. The treating team said they wanted to increase HPH's medication. HPH had had two admissions in a short period; after the first admission he had stopped taking his medication and used drugs. The treating team wanted to work with HPH to avoid a further hospital admission; the Order was necessary because they wanted to be able to monitor HPH's treatment.

The Tribunal took into account that HPH had two recent admissions and in the intervening period had used methamphetamine, stopped his medication and his mental state deteriorated to the extent that a further hospital admission was required. HPH acknowledged that he experienced anxiety and depression, but denied other symptoms. In the Tribunal's view this showed that HPH minimised or poorly understood the significance of the deterioration in his mental state during the recent episodes of illness. The Tribunal also accepted that HPH was happier with his current medication and wanted further therapy in the form of cognitive behavioural therapy. He clearly felt the weight of supervision and monitoring by family and others as a considerable burden. It was important for him to feel that he was having a say. HPH wanted to get back to work and to routines and activities which he felt would benefit him. Taking these factors into account, the Tribunal concluded that an Order was not likely to enhance HPH's understanding of his illness or ensure compliance with treatment. HPH was more likely to engage in treatment when he was not compelled or forced; an Order was likely to be counter-therapeutic. The Tribunal took into account the principles of the Act, particularly that treatment should be provided in the least restrictive way and that mental health services should be provided with the aim of bringing about the best possible therapeutic outcomes and to promote recovery and full participation in community life. The Tribunal concluded that HPH could be treated voluntarily, without the need for an Order.

When deciding whether to make an Order allowing a person to be treated with ECT, the Tribunal must decide whether there is a less restrictive way for the person to be treated. When making ECT decisions, the Tribunal must have regard to the views and preferences of the person (about ECT and alternative treatments) and the views of their nominated person, guardian, and carer. The Tribunal must also consider the likely consequence for the person if ECT is not performed and any second psychiatric opinion that the person has obtained.

In *CTN* [2017] VMHT 12, the patient was diagnosed with schizoaffective disorder. His mental health deteriorated after his medication was reduced due to side effects. CTN was admitted to hospital and refused to have his medication increased back to previous levels. His doctor applied to the Tribunal to perform a course of ECT on CTN. CTN's lawyer said that CTN understood that ECT may reduce the length of his hospital admission, however, he did not want ECT because it was more invasive; he agreed to reintroduce his medication. CTN's lawyer said the medication was a less restrictive way for CTN to be treated. CTN's doctor said the treating team was concerned that he would deteriorate due to avoiding oral medication. He also noted that CTN was agreeing to a lower dose of medication, when in fact, he may need a higher dose; it was also difficult to compel someone to take oral medication. CTN's treating doctor said ECT would likely allow CTN to be managed less restrictively in the community after an acute course of ECT.

The Tribunal considered CTN had a strong preference to avoid ECT and this appeared to have been the motivation for accepting the recommencement of oral medication. During the hearing he also appeared prepared to negotiate around the higher dose as recommended by the treating team. CTN was clear in his preference for medication rather than ECT, and he understood that if he refused it, the treating team's treatment plan would be to apply for ECT again. When considering CTN's views and preferences, the Tribunal accepted that a person is entitled to choose one thing they do not like (in this case oral medication) over something that they like even less (that is, ECT). The Tribunal had regard to CTN's preference, but it is also required to have regard to the likely consequences if ECT is not performed. In CTN's case, he may need a longer hospital stay and it may take longer for him to return to his baseline mental state. This was something that CTN understood and had contemplated. At the hearing, he appeared to understand the consequences if he again refused oral medication. The Tribunal was therefore satisfied that there was a less restrictive way for CTN to be treated and this criterion was not satisfied.

Illustration 4

When the Tribunal makes a Treatment Order, it must decide whether the person should receive treatment in hospital or in the community

If the Tribunal decides to make a Treatment Order, it must also decide whether the Order is an Inpatient Treatment Order, which requires the person to receive treatment in hospital, or a Community Treatment Order. The Tribunal can only make an Inpatient Treatment Order if a person cannot be treated in the community. The *Mental Health Act 2014* does not list any considerations the Tribunal must take into account when deciding what type of Order to make. The below cases are examples of the types of considerations the Tribunal has taken into account this year.

In *EPW* [2016] VMHT 80, the patient had been subject to a year-long Community Treatment Order and her treating doctor applied to the Tribunal to make a further Treatment Order. At the hearing, the Tribunal was informed that the Community Treatment Order had been varied to an inpatient setting on several occasions over the last year due to EPW failing to take medication, lack of engagement with the treating team and substance use. At the time of the hearing, she was being treated in the community. EPW did not to attend the hearing. The Tribunal decided all of the treatment criteria were satisfied. EPW's doctor submitted that she needed intensive community treatment with antipsychotic medication and case management. EPW also needed drug and alcohol counselling. EPW's treating team proposed that a 52-week Community Treatment Order was necessary on the basis it would facilitate ongoing treatment, three-monthly psychiatric reviews, close community support, including supervision of medication compliance, general support and counselling, and monitoring of EPW's physical health.

The Tribunal noted that it was required to make determinations as required by the Act, and in so doing, it should take a holistic, solution-focused and recovery-oriented approach. The Tribunal must have regard to the mental health principles set out in the Act, specifically that persons receiving compulsory mental health treatment should be involved in all decisions about treatment and recovery and should be able to participate in those decisions and have their views and preferences for treatment respected. In addition, persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.

In deciding the appropriate treatment setting, the Tribunal placed very significant weight on the following factors. EPW's case manager gave evidence that since discharge from hospital, EPW's mental state had fluctuated and a few days before the hearing she had been 'chroming'. EPW had had a significant number of inpatient admissions since 2004. There had been several variations from Community Treatment Orders to Inpatient Treatment Orders during the previous year. EPW's admissions to hospital were because she was not taking her antipsychotic medication. She had failed to attend two reviews since discharge from hospital and engaged in ongoing and entrenched illicit drug use. EPW demonstrated a lack of understanding that her drug use has an adverse effect on her mental health; she continued to use drugs.

EPW was pregnant at the time of the hearing and the Tribunal was also concerned of EPW's high exposure to risks if she were to experience obstetric complications as she lived alone and had no immediate family support. The Tribunal was also concerned that EPW may not recognise or be able to deal with early labour or other related complications in respect of her pregnancy if under the influence of illicit drugs. The Tribunal noted that the setting of a Treatment Order is ultimately a point in time assessment made on the day of the hearing. Despite the treating team's submission that EPW could be treated under a Community Treatment Order, the Tribunal was persuaded that on balance, the immediate treatment that EPW required could not be provided in the community and therefore made an Inpatient Treatment Order.

In *NVD* [2016] VMHT 87, the patient had a long history of mental illness dating back to the late 1990s, which had required eight hospital admissions in the period from 1999 to 2010, and community care by a continuing care team until her current admission. She had been diagnosed as suffering from schizoaffective disorder. NVD also had a long history of substance abuse, including amphetamines, from which she reported six months abstinence, and regular cannabis use, which she admitted using prior to the current admission.

NVD's lawyer said she could be treated on a Community Treatment Order. NVD's lawyer said that hospital heightened NVD's anxiety, insecurity and frustration; she would recover more quickly at home. She could be treated as a voluntary patient because a close friend intended to move in with NVD, and would provide her with support, make sure she took her medication, and bring her back to hospital if necessary. NVD's friend said he would take her to appointments and if there were any problems at home, he would bring her straight into hospital. NVD told the Tribunal she would attend her appointments at the community clinic and would be more comfortable with the staff there, because she knew and trusted them.

Dr AP said NVD needed to remain in hospital while her medication was still being adjusted and until her mental state stabilised, in particular her fluctuating mood. In her view, NVD still needed a lot of nursing support – more than her friend could provide. However, the Tribunal considered it was likely NVD would be less stressed at home and her treatment and recovery could continue there, given her stated satisfaction with her medication and the staff at the community clinic and her preference to be treated in the community. While the Tribunal accepted that premature discharge from hospital could be risky for NVD, the risk did not appear to be serious, taking into account the level of support available to her and the evidence that, if there was any deterioration in NVD's mental state, or concern about her adherence to prescribed treatment, she could be brought quickly back to hospital. The Tribunal was accordingly satisfied that the treatment NVD required could be provided in the community and therefore made a Community Treatment Order.

Part Three:
Embedding the mental health principles in the Tribunal's work

'The Tribunal is required to make determinations as required by the Act and, in so doing, it should take a holistic, solution-focused and recovery-oriented approach.

The Tribunal must have regard to the mental health principles set out in section 11 of the Act, specifically that persons receiving compulsory mental health treatment should be involved in all decisions about treatment and recovery and should be able to participate in those decisions and have their views and preferences for treatment respected. In addition, persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.'

(Tribunal statement of reasons in EPW [2016] VMHT 80).

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. The Tribunal's commitment to upholding these principles in our hearing and administrative functions is reflected in our vision, which pledges us to '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'. More broadly, our goals and the strategic actions that flow from them are focused on continuous improvement in the promotion and realisation of the Act's mental health principles.

Part Three describes how the 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 supporting work of the Tribunal's administrative staff reflect the principles of enhancing consumer participation, recovery and respect for rights, and autonomy.

This Part provides brief updates on projects we reported on in last year's Annual Report, highlights new initiatives and foreshadows projects we expect to commence or complete during 2017-18.

The mental health principles

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

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

3.1 Consumers and carers: maximising opportunities for participation and engagement

Improving consumer and carer participation and engagement in hearings and collaborating closely with consumers and carers on the design of Tribunal resources continues to be a high priority for the Tribunal. The Tribunal's work in this area demonstrates our ongoing commitment to involving consumers and carers in all decisions about treatment and recovery, to supporting consumers to make or participate in such decisions, to respecting the rights, dignity and autonomy of consumers and to recognising and respecting the role of carers.

This year, the position of consumer consultant was replaced with the new and expanded senior role of Consumer and Carer Engagement Officer. A member of the Tribunal's leadership team, the Consumer and Carer Engagement Officer facilitates strategic and practical contributions from consumers, carers and members of the lived experience workforce[2] in the work of the Tribunal, including advice on the collaborative design of Tribunal strategies, policies and procedures.

The Consumer and Carer Engagement Officer coordinates and supports the Tribunal Advisory Group (TAG). The TAG meets on a bi-monthly basis and includes consumers, carers and consumer and carer workers.

Following the success of the Tribunal's first Consumer and Carer Forum in 2015, the TAG ran another forum at the Melbourne Town Hall on 16 November 2016, which was attended by more than 120 people. The theme of the forum was 'Enhancing our Act' and the event included updates and reports on various projects, as well as a panel Question and Answer session where Tribunal members answered questions from the floor. A summary of the panel discussion is available on the Tribunal's website.

In addition to the forum, the TAG has worked on a number of projects this year, including:

- finalising the brochure *'Your rights at a Tribunal hearing'* provided to consumers, carers, nominated persons and other persons who are entitled to receive notification of a Tribunal hearing
- formulating Frequently Asked Questions (FAQs) for the Tribunal's website, directed mainly at consumers, carers and other hearing participants
- continuing to advise the Tribunal on website content and the development of various initiatives such as the new statement of reasons template and the Tribunal's resources relating to access to documents
- obtaining ethics approval for a pilot 'Experience of Tribunal hearing' survey due to be rolled out in mid-2017. The pilot survey will inform development of a regular participant survey with the aim of identifying enhancements to participation strategies and improvements to Tribunal hearings and resources.

Priorities identified for future TAG work are:

- continuing to improve the Tribunal's website and structure
- making information accessible in a variety of formats to encourage more consumers and carers to participate in treatment decision-making and attend hearings.

2. The lived experience workforce comprises people who are employed in declared roles for specific skills that reflect their personal experiences and knowledge of mental health issues, treatment and recovery. A lived experience worker identifies as being, or having been, a mental health consumer or the carer of a person with mental illness.

3.2 Solution-focused hearings: completed work and future plans

Solution-focused hearings aim to engage hearing 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 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 Act's 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 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 guide was intended 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. In last year's Annual Report, the Tribunal reported that we had 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 published two additional chapters to the guide: one covering solution-focused hearings for young people and the second focusing on older people. Drawing on the Tribunal's experience and the invaluable input of stakeholders, these chapters explore a framework of best practice for conducting hearings that maximise the participation of young persons and older people in Tribunal hearings and are sensitive to the particular issues that might arise for these groups of consumers.

These two chapters illustrate 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.

In 2017-18, we plan to further expand the *Guide to Solution-focused Hearings in the Mental Health Tribunal* by exploring ways to improve the participation of family and carers in Tribunal hearings. This work will enhance the alignment of Tribunal hearings with the mental health principles related to involving carers (including children) in decisions about treatment and recovery, and recognising, respecting and supporting the role of carers.

Solution-focused case study

The consumer, who was experiencing a relapse of his chronic schizophrenia, had been an inpatient in an aged-care unit for approximately six months. The hearing was triggered by the treating team's application for a further Treatment Order. The treating team was seeking an Inpatient Treatment Order (ITO) for the maximum duration (26 weeks), although the information before the Tribunal indicated that they wanted the patient to remain an inpatient only until his next depot medication (administered by injection) a few days away, after which time they planned to vary the ITO to a Community Treatment Order (CTO). The consumer had recently been having leave each day and this had been occurring without incident. The consumer was legally represented.

At the start of the hearing the consumer was angry, agitated and mistrustful of both the Tribunal and the mental health 'system' generally. Two members of the Tribunal eventually managed to engage with the consumer and have a productive conversation with both him and the treating team. It was clear that the consumer had a poor understanding of his illness, but that he would accept depot medication to avoid inpatient treatment and be able to go home. The Tribunal therefore focused on that goal. They questioned the treating team as to why the consumer could not be on a CTO immediately and also talked with the consumer and the treating team about how he would manage at home. Based on the evidence it received, and despite initial misgivings about the consumer's ability to cope at home, the Tribunal decided to make a CTO.

By the end of the hearing, the patient was far more relaxed and was engaging positively with everyone involved in the hearing.

What worked and why?

In this case, the solution-focused strategies that worked best included the following:

- focusing on what really mattered to the consumer (going home and not coming back to hospital) and how this could best be facilitated (by turning up for depot medication and co-operating with the treating team)
- using direct, honest and appropriate language to which this consumer responded well
- exploring the perspectives and position of both the consumer and the treating team to identify potential options with which everyone was satisfied. This required the consumer to engage with the process, something he was more prepared to do after he observed the Tribunal was willing to ask questions of the treating team about what needed to be put in place for his successful transition home
- only two members participating in questioning the hearing participants. Once the consumer became more receptive and engaged with two members, there was nothing to be gained by the third member asking questions. This approach maintained the consumer's focus and reduced repetition and the length of the hearing.

3.3 Treatment issues: exploring the Tribunal's role

The Tribunal's work regarding solution-focused hearings has formed the basis of a dialogue with mental health services about the extent of the Tribunal's role in relation to treatment.

By vesting the Tribunal with an expanded and active range of functions, and enshrining those functions in a framework that embodies contemporary mental health principles, the Act has drawn the Tribunal into the 'treatment space'. Charged with the responsibility of making Treatment Orders, the Tribunal must understand what treatment it is being asked to compel a person to have. The Tribunal must also be satisfied that that treatment, understood holistically (in other words, extending beyond medication), meets certain minimum standards, namely those that are expressed in the mental health principles.

Exploration and promotion of the principles inherently requires scrutiny of treatment. For example:

- Without a clear picture regarding current and proposed treatment for a person, it is not possible to ensure treatment is the least restrictive possible, is recovery-oriented and is a product of supported decision-making.
- The practical implications of dignity of risk can only be understood if risks are clearly articulated and substantiated and the link to proposed treatment is clear.
- Ensuring treatment is responsive to the particular needs of individuals from marginalised or vulnerable groups, and holistic in terms of a person's medical and other health needs, requires treatment and recovery plans that are framed around an individual and their circumstances – including, but extending beyond, the particular symptoms of their mental illness.

However, there continues to be a lack of clarity and at times disagreement about the scope of the Tribunal's role or the parameters of the Tribunal's interest in treatment issues. For this reason, the Tribunal has commenced a dialogue with members and health services about its role in the treatment space. The March 2017 members' forum incorporated a workshop on this issue (including discussion of various case studies designed to trigger reflection and discussion) and the Tribunal's President recently gave a lecture on the subject. Exploration of this complex and important aspect of the Tribunal's role will continue throughout 2017-18.

3.4 Tribunal members: professional development, continuous improvement and embedding solution-focused hearings

Current professional development opportunities for Tribunal members include two members' forums each year, two shorter evening seminars on topical issues or subjects of interest, and members' peer review group meetings. Newly appointed members are allocated a mentor for a period after they commence work on the Tribunal. This year, the Tribunal expanded our professional development activities to include a program where members are able to observe hearings. This allows members the opportunity to observe the hearing process and the practice of other members, particularly those from the same member category as themselves.

The resources supporting the Continuous Improvement Performance Model include written material that provides standards and guidance for members; in addition, the professional development program is designed to enhance members' skills and knowledge and to encourage best practice. Members are supported to conduct hearings where consumers and their families and carers actively participate and their views and preferences are heard and taken into account. The consumer's recovery goals are central in that process. Ideally, the conduct of a hearing should respect not only the consumer, their family and carers, but also respect and acknowledge the serious impact of the Tribunal's decision on these people's lives. Tribunal hearings that combine rigorous scrutiny of the relevant criteria with a focus on the best possible therapeutic outcomes and that are solution-focused are grounded firmly in the principles of the Act. The Tribunal's professional development activities aim to assist and develop members' skills in this context.

3.5 Access to documents: a new Practice Note

To ensure hearings are procedurally fair, it is important that consumers have an opportunity to prepare for their hearings and to respond to what the treating team puts forward as evidence to support the making of an Order. To do this, they need to know what written material the treating team will put before the Tribunal at the hearing – usually a clinical report and the whole or parts of the clinical file.

The Act enshrines the right of consumers to access documents before their hearing, requiring services to give them access to all documents 'in connection' with the proceeding at least 48 hours before the hearing. However, the Act also creates an exception to this general rule by allowing the authorised psychiatrist to ask the Tribunal to deny a patient access to a particular document or documents if satisfied that disclosing the documents may cause serious harm to the patient or another person.

In practice, consumers' right to access documents raises complex issues and has given rise to considerable confusion. To clarify the Tribunal's approach to access to documents and hearings to deny access to documents, in 2016-17 the Tribunal released a new Practice Note on *Access to Documents in Mental Health Tribunal hearings*, along with related resources presenting the same material in an accessible format.

The Practice Note is another example of how the mental health principles inform and guide the Tribunal's strategic projects and activities. By clarifying when documents must be provided and clearly regulating the occasions when they are not, the Tribunal seeks to not only improve compliance with the Act and consistent decision-making, but also to improve consumers' access to information relevant to their hearing. This helps consumers to understand and be involved in decisions about their treatment and recovery. In this way, the new Practice Note has the effect of respecting and promoting consumers' rights (particularly their right to a procedurally fair hearing, dignity and autonomy).

3.6 Better tools and resources: clinical report templates

As previously stated, the Tribunal is committed to maximising consumer participation in hearings and building excellence in mental health law. With this aim in mind, the Tribunal develops tools and resources to assist health services, consumers, carers and others to better understand the legal criteria and related considerations the Tribunal must take into account during hearings.

One such tool is the comprehensive suite of templates the Tribunal develops and publishes to guide the preparation of clinical reports by health services. The Tribunal's Rules and Practice Notes require the treating team to prepare these reports for every Tribunal hearing. The clinical report is also a way of ensuring that, as well as exploring whether all the criteria for compulsory treatment (and compulsory ECT treatment) apply, hearings focus on the consumer's path towards the best therapeutic outcomes and less restrictive treatment. Comprehensive clinical reports, which must be provided to consumers 48 hours before the hearing, also ensure that consumers have an opportunity to prepare for their hearing. In these important ways, clinical reports promote and respect consumers' rights and are an essential element of procedural fairness.

In last year's Annual Report, we reported on the development of a new clinical report template for patients in Secure Extended Care Units (SECU). The SECU report template was finalised during this reporting period and is now in operation at all Victorian SECUs.

In addition, this year we revised the template for ECT clinical reports. The previous template was developed in the lead-up to the commencement of the Act. At that time, there was not only a lack of experience with the criteria for ECT Orders, there was also no experience of ECT hearings to draw upon, as the former Mental Health Review Board had no role in relation to authorising ECT. Subsequent experience highlighted that the previous report template failed to elicit information that is important for the determination of ECT applications.

Accordingly, the revised template, which has been rolled out in health services across the state, includes additional questions that better reflect the issues and questions that are discussed at hearings. To further improve the quality of evidence and understanding of the Tribunal's ECT jurisdiction, the Tribunal has commenced work on a set of guidelines for ECT hearings, which we expect to finalise during 2017-18.

The Tribunal expects both new report templates to contribute directly to the integration of the mental health principles in hearings, particularly the principles around bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life, respecting and promoting rights and ensuring that treatment occurs in the least restrictive way possible.

3.7 Transparency and understanding: a new statements of reasons template and categorised list of published statements of reasons

Work undertaken for the Tribunal's Continuous Improvement Performance Model (CIPM) has included development of a new statement of reasons template for Treatment Order hearings, with the aim of making the Tribunal's statements of reasons easier to read for consumers and to encourage the use of plain language. In 2016-17, a CIPM working group conducted extensive consultation on the new template, including with the consumers and carers and consumer and carer workers represented on the Tribunal Advisory Group. In the 2017-18 financial year, the Tribunal will work on statement of reasons templates for other hearing types.

More transparent, easy-to-read statements of reasons allow consumers to better understand and reflect on their hearings, as well as on their treatment and recovery more generally. Statements of reasons can highlight other medical issues and individual needs, and identify the next steps and actions needed for the consumer to move towards voluntary treatment (as the case study of YPC below illustrates). By highlighting the remaining obstacles to voluntary treatment and what is needed to overcome them, clearer statements of reasons may assist consumers to see how they can progress along the pathway towards the least restrictive possible treatment – with the ultimate goal of voluntary treatment.

Accordingly, the Tribunal's work on improving statements of reasons reflects the mental health principles by facilitating the best possible therapeutic outcomes, promoting recovery and full participation, involving consumers in decisions about their treatment and recovery, and supporting them to make and participate in decisions.

Related to this work is the publication of de-identified statements of reasons on the AustLII website and the categorised list of published statements of reasons mentioned in Part 1 of this report. Publication of and assistance in 'navigating' these documents leads to improved understanding of the legal criteria and other factors – including the mental health principles – that the Tribunal takes into account in hearings.

YPC [2016] VMHT 85 – statement of reasons highlighting steps towards less restrictive treatment

The hearing for YPC involved a long-stay inpatient with complex needs. Facilitated by intensive case management by the Tribunal's registry, the patient's guardian and social worker as well as lawyer, family members and treating team all attended the hearing. After considering the legal criteria, the Tribunal made an Inpatient Treatment Order but clearly set out the steps towards less restrictive treatment:

'The Tribunal anticipated that before community treatment would be a realistic option, the following would need to take place:

- *YPC would have a clearly identified address, and an identified mental health service that would take over his care;*
- *his new… mental health service would need a period of time to get to know him and be aware of the risks he presented, and his concerns regarding his medication; and*
- *he would have had some successful periods of leave.*

The Tribunal made it clear to YPC that the completion of the above did not mean that he was ready for community treatment. It was an articulation of a starting point that this division of the Tribunal viewed as appropriate before community treatment would be realistic.'

HPH [2016] VMHT 78 – statement of reasons highlighting how the Tribunal took the mental health principles into account

In considering the criterion (d) (whether there was a less restrictive means reasonably available to enable the patient, HPH, to receive the immediate treatment), the mental health principles were one of the factors in the Tribunal's decision that HPH could be treated on a voluntary basis. The Tribunal's reasoning includes the following passage:

'HPH explained himself well at the hearing. He clearly felt the weight of supervision and monitoring by family and others as a considerable burden. It was important for him to feel that he was having a say. HPH wanted to get back to work and to a routine and activities which he felt would benefit him. The Tribunal considered that this was a positive indication that HPH wanted to progress his life and that recovery from his recent periods of illness would be an important part of that. Taking these factors into account, the Tribunal concluded that an Order was not likely to enhance HPH's understanding of his illness or to ensure compliance with treatment. HPH was more likely to engage in treatment when he was not compelled or forced. The Tribunal took into account the principles of the Act, particularly that treatment should be provided in the least restrictive way and that mental health services should be provided with the aim of bringing about the best possible therapeutic outcomes and to promote recovery and full participation in community life.

The Tribunal concluded that HPH could be treated voluntarily, without the need for an Order. There was a less restrictive way for HPH to receive treatment and as a result, this criterion was not satisfied.'

3.8 Tribunal research project: duration of Orders

A Tribunal research project currently underway also highlights how the Tribunal takes the principles of the Act into account in setting the duration of Treatment Orders.

In contrast to its predecessor, the Mental Health Review Board, the Tribunal is a primary decision maker rather than a review body. In this context, one of the reforms of the Act was to shift responsibility for deciding the initial maximum duration of a Treatment Order from authorised psychiatrists to the Tribunal. This year, the Tribunal has endeavoured to explore this aspect of its decision-making by setting up a research working group (RWG) comprised of Tribunal members and staff.

The RWG is exploring how the Tribunal decides the duration of Treatment Orders and is doing so by focusing on matters where the Tribunal makes a Treatment Order for a duration that is different to that requested by the authorised psychiatrist. The first phase of this investigation will focus on two questions:

- To what extent is there a difference between the duration of Treatment Orders requested by the authorised psychiatrist and Treatment Orders made by the Tribunal?
- What are the factors or considerations the Tribunal is taking into account when making Treatment Orders that are more or less than the duration requested?

To answer the second question, the RWG considered various factors regularly considered by the Tribunal and grouped them into four main categories: (i) insufficient information for care and risk assessment; (ii) parties' presentation; (iii) congruence with principles of the Act; and (iv) oversight required by the Tribunal. The initial data indicates that deciding the duration of Orders is influenced largely by ensuring congruence with the principles of the Act.

In next year's Annual Report, we will be in a position to report on this research in more detail. We also hope to use the data collated from these early stages of the project to further explore and seek to understand this aspect of the Tribunal's decision-making and its impact on consumers, carers and treating teams.

3.9 Service improvements: collaboration with health services and the Department of Health and Human Services

Finally, during 2016-17 the Tribunal collaborated with health services and the Department of Health and Human Services on two significant, related service enhancements to support hearings.

On 28 November 2016, after a three-month validation and pilot project, the electronic interface between the Tribunal and health services was implemented, replacing a manual system of hearing lodgements. The interface enables electronic extraction of information to ensure that the Tribunal can conduct hearings for compulsory patients throughout Victoria.

An important and related piece of work conducted alongside this project was the establishment of improved processes for compulsory notifications (that is, those persons who are required to be notified of hearings, including nominated persons and carers). This work had two core objectives. First, we focused on ensuring the Tribunal was correctly informed of those people entitled to be notified of hearings, which has the effect of involving carers (and others) in decisions about treatment and recovery wherever possible and recognising, respecting and supporting their roles. The second, equally important, objective was to improve the accuracy and currency of notification details to protect consumers' right to privacy.

Apendix A
Financial Summary

The table below provides a summary of the Tribunal's funding sources and expenditure for 2016-17 to 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

	2016–2017	2015–16	2014–15
TOTAL	***$8,249,445***	*$8,109,551*	*$7,600,000*

EXPENDITURE

Full and part-time member salaries	**$1,308,120**	$1,343,608	$1,586,467
Sessional member salaries	**$3,792,832**	$3,260,481	$2,920,188
Staff Salaries (includes contractors)	**$1,576,658**	$1,875,774*	$1,418,071
Total Salaries	**$6,677,610**	$6,479,866	$5,924,726
Salary On costs	**$1,090,767**	$1,078,171*	$1,036,571
Operating Expenses	**$486,944**	$548,733	$584,707
Depreciation**	**$0**	$0	$50,409
TOTAL	***$8,255,321***	*$8,106,767*	*$7,596,413*
Balance	**-$5,876**	$2,784	$3,587

* *This figure has been updated to reflect correct accounting procedure. In 2015-16 $380,134 attributed to Salary and On costs should have been attributed to Staff Salaries.*

** *Depreciation is centrally managed within the Department of Health and Human Services and is no longer reflected in the Tribunal Expenditure.*

Apendix B

Membership List as at 30 June 2017

Full-Time Members	Period of Appointment
President	
Mr Matthew Carroll	1 June 2003 – 1 June 2020
(First appointed President 23 May 2010)	
Deputy President	
Ms Troy Barty	1 June 2003 – 9 June 2018
(appointed Deputy President 15 March 2017)	

Senior Members (Full-time)	
Ms Emma Montgomery	25 Aug 2014 – 9 June 2018
Mr Tony Lupton	25 Feb 2016 – 24 Feb 2021
(appointed Senior Legal Member 15 March 2017)	

Part-Time Members: Legal	
Mr Brook Hely	25 Feb 2011 – 24 Feb 2021
Ms Kim Magnussen	25 Feb 2011 – 24 Feb 2021

Part-Time Members: Psychiatrist	
Dr Sue Carey	25 Feb 2011 – 24 Feb 2021

Part-Time Members: Community	
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
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
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 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
Ms 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 *(retired 26 November 2016)*	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 Nicholas Owens	10 June 2013 – 9 June 2018
Dr Gunvant Patel	11 March 2014 – 9 June 2018
Dr Philip Roy	9 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 *(retired 26 November 2016)*	1 June 2003 – 9 June 2018
Dr Jennifer Torr	11 March 2014 – 24 Feb 2021
Dr Maria Triglia	25 Feb 2011 – 9 June 2018
Assoc Prof 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
Mr Duncan Cameron	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 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
Adj Prof Bill Healy	5 Sept 2000 – 9 June 2018
Mr Ben Ilsley	10 June 2013 – 9 June 2018
Mr John King	1 June 2003 – 24 Feb 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 Sep 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 *(deceased 15 September 2016)*	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

Apendix C
Compliance reports

In 2016-17, the Tribunal maintained policies and procedures concerning the *Freedom of Information Act 1982* (the FOI Act), the *Protected Disclosure Act 2012* (the PD Act) and its records disposal authority under the *Public Records Act 1973* (the PR Act). The Tribunal has published freedom of information and protected disclosure guidelines on its website.

Application and operation of the Freedom of Information Act 1982

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

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

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

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

This financial year, the Tribunal received 10 requests for access to documents. In nine 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 freedom of information 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 and must clearly identify the documents being requested and be accompanied by the application fee ($27.90 from 1 July 2016). The request should be addressed to:

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

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

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

During the 2016-17 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:

Department of Health and Human Services
Protected Disclosures
GPO Box 4057
Melbourne VIC 3001
Telephone: 1300 131 431
Email: protected.disclosure@dhhs.vic.gov.au

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

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

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

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

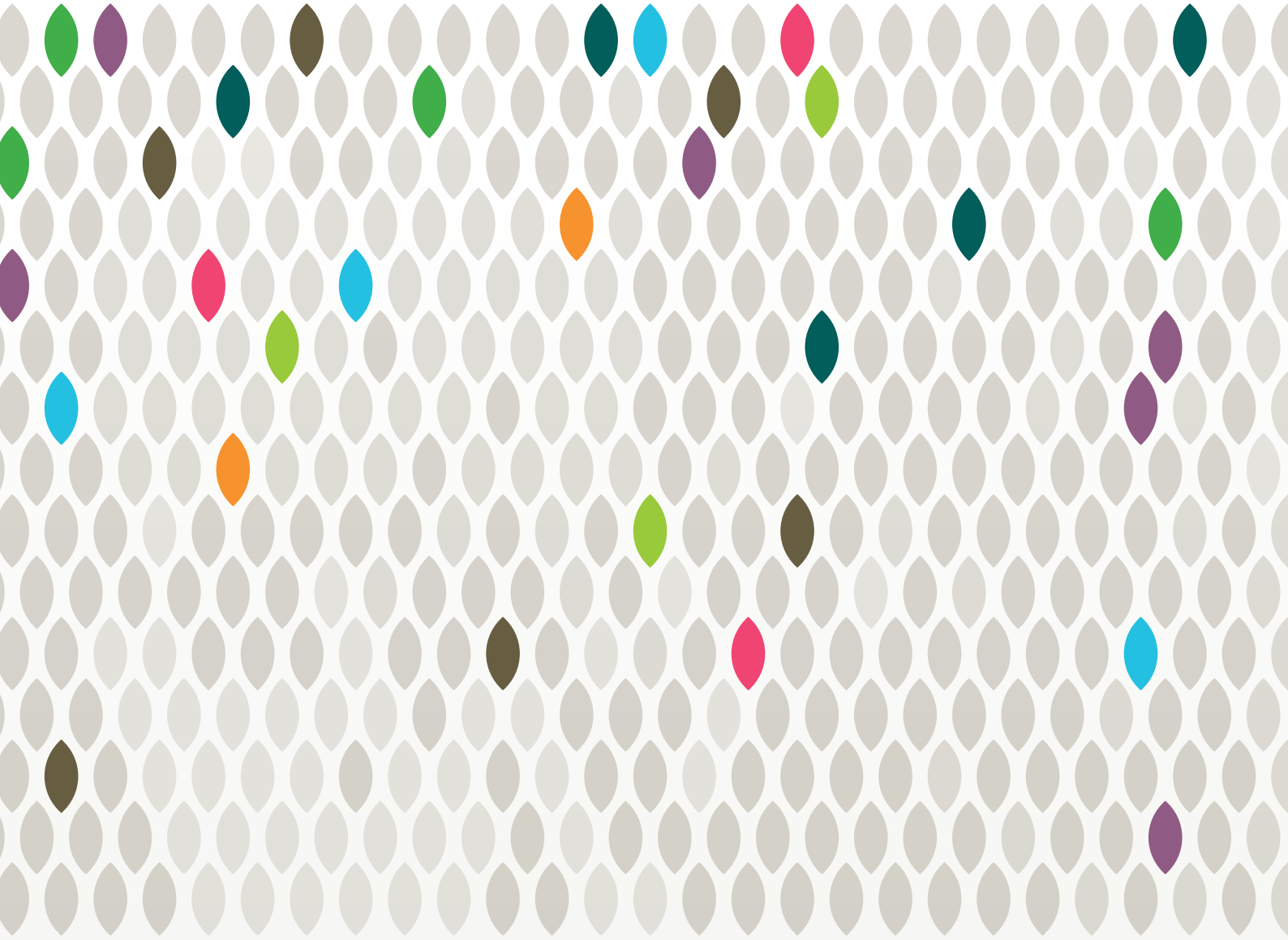
INSIDE BACK COVER
(BLANK)

Mental Health Tribunal

Level 30, 570 Bourke Street Melbourne Victoria 3000

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

Fax: (03) 9032 3223
Vic Toll Free: 1800 242 703
DX 210222 Melbourne



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