Mental Health Tribunal

2017-2018 Annual Report

Mental Health Tribunal

The Mental Health Tribunal is an independent statutory tribunal established as an essential safeguard to protect the rights and dignity of people with mental illness.

Mental Health Tribunal

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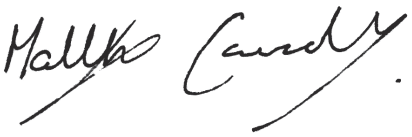
19 July 2018

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 2017 to 30 June 2018.

Yours sincerely



Matthew Carroll
President

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Terminology in this Annual Report

There is continuing debate about the most desirable or acceptable terminology to use when referring to people who receive compulsory treatment for a mental health condition. 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

Since commencement, the Mental Health Tribunal has been dynamic and open to new and improved ways to exercise our functions. We have been open to adapt or change to better meet the needs and expectations of those affected by our processes and decisions. In our fourth annual report, we can confirm that many of the initiatives commenced by the Tribunal over the previous three years have moved from a pilot or development phase into full operation. Of course, this doesn't mean we will be any less dynamic or receptive to change in the future; rather, it represents a point of consolidation that places the Tribunal in a strong position from which to reflect upon and consult about further improvements we can make.

Key achievements for the year are described in this report, and particular highlights include:

- Successful completion of the pilot of the Tribunal's *Consumer and Carer Experience of Hearing* survey, overseen by the Tribunal Advisory Group. The pilot confirmed the validity and usability of the survey tool, and the responses received as part of the pilot have already provided us with valuable feedback. We will fully implement the survey during 2018-19.
- Performance feedback is a key element of the Council of Australasian Tribunals' excellence framework. With the finalisation and commencement of the *Member Performance Feedback Framework*, the Tribunal now provides all members with structured feedback about how they are performing in their roles. Members will receive comprehensive feedback, incorporating peer and self-assessment, twice over the course of a five-year appointment.
- Moving from an ad-hoc approach where we responded to occasional requests, the Tribunal has now implemented a proactive education strategy with health services about the role of the Tribunal and how hearings are conducted. We have committed to offering training sessions at least once every year for the many services where we conduct hearings. These interactive sessions are grounded in the principles of the *Mental Health Act 2014* ('the Act'). Discussions emphasise that Tribunal hearings extend beyond what might be needed to keep someone well to include promoting rights, dignity and autonomy and making decisions about assessment, treatment and recovery that involve a degree of risk. By doing this, our education sessions are intended to promote a richer and more consistent hearing experience for all participants.

These important projects and other initiatives are pursued alongside the Tribunal's regular business.

As has been the case since we commenced operation, 2017-18 has been another busy year that saw the workload of the Tribunal increase significantly. Hearings listed rose by 6% and hearings conducted also increased by 6%. At the same time, the Tribunal managed the expansion of its jurisdiction in relation to electroconvulsive treatment (ECT) as a result of reforms introduced by the *Medical Treatment Planning and Decisions Act 2016*. Commencing operation in March 2018, this legislation allows adults who do not have capacity to provide informed consent to be administered ECT without being made a compulsory patient under the Mental Health Act, provided they have an instructional directive giving informed consent or their medical treatment decision maker gives informed consent. Approval must also be obtained from the Tribunal, which needs to consider the capacity of the person who is to be treated; whether there is no less restrictive way for the person to be treated; and whether the person has given informed consent in their instructional directive or their medical treatment decision maker has given informed consent.

A distinctive feature of 2017-18 was increased public scrutiny of the Tribunal's operation and decision-making. This is entirely appropriate and should be encouraged: mental health laws impact significantly upon individuals and there should be ongoing consideration of how these laws operate and whether they strike an appropriate balance across different interests. The Tribunal has always taken its obligation to be accountable very seriously. We publish de-identified statements of reasons to explain how we are interpreting and applying the law, and we publish quarterly data relating to hearings and determinations. This material is intended to inform public discussion and commentary and, as a statutory decision maker, the Tribunal does not ordinarily participate directly in that discourse. However, two instances from this year warrant comment:

- As part of its ground-breaking *Justice Project*, the Law Council of Australia has raised concerns regarding the low levels of legal representation in Tribunal hearings. This is both an accurate and a reasonable observation, and the Tribunal has repeatedly confirmed the important role and contribution of legal representatives in hearings, which is highly valued. However, when examining the rates of legal representation in Tribunal hearings, it is vital to avoid creating a misconception that having a lawyer is necessary to ensure a fair hearing or that it determines outcomes. Unlike the adversarial process in courts and some tribunals, where it is up to each party to present evidence themselves or through their lawyer, the Mental Health Tribunal is inquisitorial, exploring the relevant issues proactively through questions and discussion with participants: the person receiving treatment, the people who support them and their treating team. The Tribunal embraces this role. We ask questions to understand the full breadth of a situation in hearings that can last two to three times longer than most of our counterparts in other jurisdictions. We use this time to conduct solution-focused hearings in which participants have an opportunity to explore how impediments to less restrictive treatment might be resolved. Legal representatives are valuable contributors to this process, but it occurs whether or not they are involved.

- In media commentary and related journal articles, the Tribunal was strongly criticised for not focusing on the decision-making capacity of compulsory patients when making decisions regarding Treatment Orders. It was also argued that by not examining a person's capacity, the Tribunal was failing to take their wishes into consideration. This criticism was ill-founded for two reasons: first, the Act deliberately excludes decision-making capacity as a criterion for the making of compulsory Treatment Orders. Secondly, the Act makes the preferences of a compulsory patient a relevant consideration in any decision the Tribunal makes about Treatment Orders, regardless of their capacity. A number of the case studies included in this report illustrate the Tribunal's commitment to understanding individual preferences and wishes, and how central they are to our decision-making.

This year included a member appointment round. As a result, there were significant changes in the Tribunal membership *(detailed at right)*. I extend my thanks to those members who have left the Tribunal for their invaluable contributions over the course of many years. I also want to thank Maggie Toko (CEO of the Victorian Mental Illness Awareness Council) and Marie Piu (CEO of Tandem) who provided their expertise and gave up an enormous amount of time to sit as independent members of the interview panels for member appointments. Having the peak consumer and carer bodies involved in member appointments in this way marked a significant milestone in the evolution of the Tribunal's relationship with the mental health sector.

This year the Tribunal finalised a new strategic plan that will direct our work through to mid-2021 (the plan is featured in Part 3 of this report). The development of this plan was an opportunity to recommit the Tribunal to its central focus on consumers and carers, and to promoting the realisation of the mental health principles as part of their lived experience when engaged with treatment under the Act. Our plan also recognises the critical role of health services and seeks to promote positive, constructive engagement between these services and the Tribunal. We look forward to continuing to work collaboratively on the implementation of this plan.

The professionalism, hard work and commitment of the Tribunal's members and staff, alongside the advice and direction of the consumer and carer representatives on our Tribunal Advisory Group, gives rise to the initiatives, achievements and outcomes detailed in this report. My sincere thanks to all of you for your important and valued contributions.

Matthew Carroll
President

Membership changes during 2017-18

Over the course of 2017-18 a number of members retired or completed their terms of appointment. Beyond sitting on hearings members contribute to the Tribunal in a variety of ways. We acknowledge the contribution of, and say farewell to:

Community Members:

Ms Elizabeth Gallois
Ms Patricia Harper
Adj Prof Bill Healy
Dr Margaret Leggatt
Ms Fiona Lindsay
Mr Gordon Matthews
Ms Liza Newby
Prof Trang Thomas

Legal Members:

Ms Pamela Barrand
Dr Peter Condliffe
Mr David Eldridge
Mr Owen Mahoney
Prof Bernadette McSherry
Mrs Anne O'Shea
Mr Robert Phillips
Mr Nick Sciola
Ms Kara Ward

Psychiatrist Members:

Dr Tom Callaly
Dr Yvonne Greenberg
Dr Robert Millard
Dr Gunvant Patel
Dr Sally Wilkins

Registered Medical Members:

Dr Adeola Akadiri

The Tribunal was also delighted to welcome a number of new members:

Community Members:

Ms Katrina Clarke
Ms Angela Eeles
Mr Bernie Geary
Ms Jacqueline Gibson
Ms Erandathie Jayakody
Mr Anthony Stratford
Mr Graham Rodda

Legal Members:

Ms Meghan Butterfield
Ms Arna Delle-Vergini
Mr Christopher Thwaites
Mr Stuart Webb
Ms Tania Wolff

Psychiatrist Members:

Dr Peter Adams
Dr Ruth Borenstein
Dr Peter Burnett
Dr Peter Churven
Dr Sheryl Lawson
Dr Michael McCausland
Dr Philip Price
Dr Robert Shields
Dr Susan Weigall

Registered Medical Members:

Dr Anthony Barnes

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 an adult 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

That the principles and objectives of the *Mental Health Act 2014* are reflected in the experience of consumers and carers.

Our mission

The Mental Health Tribunal decides whether a person receives compulsory treatment under the *Mental Health Act 2014*. Our hearings focus on human rights, least restrictive treatment and the participation of consumers, carers and clinicians.

Our values

We are:

- Collaborative
- Fair
- Respectful
- Recovery focused

Our strategic priorities

- Ensuring fair, consistent and solution focused hearings
- Promoting the realisation of the principles and objectives of the *Mental Health Act 2014*
- Using technology to make our processes more efficient and sustainable

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.

Part 1
Functions, Procedures and Operations of the Mental Health Tribunal

The Tribunal's core business is to perform its functions as set out in the *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 an adult 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 to the Tribunal at any time while the Order is in force to have the Order revoked. The determination of the Tribunal must be to either 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 Court Secure Treatment Order 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 Court Secure Treatment Order 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 where they will be detained and treated. Pursuant to s279 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives the security patient to determine whether the relevant criteria apply to the security patient, and thereafter at 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 an adult if they are considered to not have capacity to give informed consent to ECT, or for any person under the age of 18.

If one or more of the criteria is not met, the Tribunal must refuse the Order. If the criteria are met, when making an Order the Tribunal must set the duration of the ECT Order and the number of ECT treatments.

For adults, whether they are on a Treatment Order or voluntary 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 voluntary adults there is an additional requirement that either:

- they have an instructional directive in an advance care directive giving informed consent to ECT; or
- their medical treatment decision maker has given informed consent in writing to the treatment.

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

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

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

ECT applications must be listed and heard within five business days after receiving the application. Urgent ECT applications must be listed and heard as soon as practicable and within five business days. An urgent hearing of the application may be requested if the 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.

Case Study

Making decisions: How the Tribunal considers whether a person will suffer serious deterioration in their mental health – what is reasonable risk?

After determining whether a person has a mental illness, the second treatment criterion of which the Tribunal must be satisfied before making a Treatment Order is whether the person needs immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to themselves or another person. This year, the Tribunal explored the nuances of 'serious deterioration' and what would be reasonable risk.

In LGS [2018] VMHT 14, the Tribunal reflected upon the framework of the Act and noted that section 5(b) of the Act applies in the same way whether the person is placed on a Temporary Treatment Order by an authorised psychiatrist or a Treatment Order is made by the Tribunal.

LGS was on a 48-week Community Treatment Order when he made an application to revoke his Order. LGS was diagnosed with schizophrenia and poly-substance use and had a significant history of hospital admissions dating back to the mid-1990s. LGS's lawyer submitted that he could be treated on a voluntary basis and that any risk of serious deterioration or harm could be avoided if he was a voluntary patient.

LGS accepted the need for medication and his mental health had remained stable while he was on a very low dose depot (medication by injection). LGS had a clear preference for oral medication and told the Tribunal he would take oral medication, at a therapeutic dose, and would continue to work with the treating team. The treating team believed that a Community Treatment Order would allow more assertive treatment, but agreed that LGS would still receive assertive outreach support if he became a voluntary patient.

The Tribunal found that LGS could receive the immediate treatment he required as a voluntary patient and revoked his Treatment Order. In reaching this conclusion, the Tribunal referred to the mental health principle in section 11(1)(d) of the Act, which states that 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk'. The Tribunal accepted that revoking the Order involved some risk (LGS could become unwell again), but found the risk was reasonable and could be managed.

The Tribunal had regard to the operative principle of section 5(b), which is prevention of serious deterioration or serious harm. The Tribunal said a Treatment Order does not need to continue, particularly while a person is relatively well and in the absence of other justification, just in case an Order may be needed later. The Tribunal observed that LGS's treating team could place LGS on a Temporary Treatment Order in the future if he met the criteria for compulsory treatment. Importantly, this action could be taken to prevent serious deterioration; the treating team did not need to wait for the serious deterioration to actually have occurred before they placed LGS back on a compulsory Order.

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, generally 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 office.

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 where its services are required without the use of video-conference connections. The capacity to conduct video-conference hearings is also critical for the Tribunal 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.

1.2.3 Notice

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

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

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

1.2.4 Case management

As the Tribunal conducts over 8,000 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
- 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 3), 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 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 Performance Feedback framework. See Part 3 for details.

1.3.3 Legal representation

Legal representation is not an automatic right in Victoria and it is the responsibility of patients, with the assistance of health services, to arrange their own representation. Victoria Legal Aid and the Mental Health Legal Centre can provide free advice and legal representation at hearings. Statistics relating to legal representation are shown in Part 2.

1.3.4 Determinations and Orders

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

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

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

1.3.5 Review by VCAT

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

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

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

1.3.6 Statements of reasons

Under s198 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 mental health service and any party joined by the Tribunal. In order to protect the privacy of patients and witnesses, statements of reasons refer to all such persons by their initials only.

Publication of Statements of Reasons

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

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

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

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

Complementing the publication of statements of reasons on the AustLII website, the Tribunal's website has a catalogued index of published statements of reasons that links to the AustLII website.

1.3.7 Rules and Practice Notes

The Tribunal commenced operation with an initial set of Rules governing essential aspects of its operation, accompanied by six Practice Notes. Practice Notes deal with less common types of applications or matters that come before the Tribunal, and provide guidance on the information that needs to be available for these hearings.

Subsequent Practice Notes have been issued on Observers at Mental Health Tribunal hearings and Access to Documents prior to Tribunal hearings, including the process to be followed where an authorised psychiatrist applies to withhold documents.

All Practice Notes are available on the Tribunal's website.

1.4 Administrative operations

1.4.1 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 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.

More information about the TAG is available in Part 3.

1.4.2 Stakeholder engagement

Legal representatives

Victoria Legal Aid (VLA) is the primary provider of legal services to people having Tribunal hearings. The Tribunal meets on a regular basis with VLA to discuss issues of common interest and maintain effective working relationships.

The Mental Health Legal Centre (MHLC) also facilitates the provision of pro-bono legal representation to people on compulsory treatment orders. The Tribunal liaises with the MHLC as needed.

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 3.

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. 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

1.4.3 Educational activities

The Tribunal undertakes a range of activities to explain its role and the framework for treatment as established by the Act. This includes education sessions for health services, papers and presentations delivered by the President, Deputy President and full and part time members. More details about the Tribunal's education sessions are provided in Part 3.

The Tribunal's registry staff also engage 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.

Case Study

Making decisions: How the Tribunal considers whether a patient requires immediate treatment to prevent serious deterioration in their mental health

When conducting Treatment Order hearings the Tribunal must consider whether the patient requires immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to themselves or another person. The Tribunal considers each matter on a case-by-case basis and makes a decision based on the patient's circumstances.

In BQH [2017] VMHT 60, the patient was diagnosed with schizophrenia and had several inpatient admissions since his first contact with psychiatric services in the early 2000s. The Tribunal was satisfied that BQH had fixed false beliefs that he had suffered significant loss and damage at the hands of multiple individuals and that government agencies were conspiring against him. BQH's beliefs were present at varying levels of intensity for around 15 years and as a result BQH had isolated himself from receiving support from agencies and family.

At the hearing, the treating team said BQH needed immediate treatment to prevent serious deterioration in his mental and physical health and serious harm to himself and another person. The treating team said BQH's delusional beliefs interfered with his day-to-day life and his self-care. BQH's beliefs led him to hoard to such an extent that his house was no longer habitable and he was sleeping and cooking outside. The treating team said BQH was vulnerable and at high risk of exploitation, particularly financial exploitation. He was in debt and had longstanding unpaid bills, with only a limited income from a disability support pension. BQH was said to be at risk of becoming homeless as his house was already damaged from water leakage, which he refused to have repaired. There were no utilities or services connected to his property because he refused to pay the bills. The treating team said BQH was at risk of social isolation, but conceded he had not expressed any ideas of self-harm or suicide. BQH had threatened others in the past, including making a threat to bomb Centrelink, but he had never acted on his delusional beliefs. The treating team indicated that it was in BQH's best interests to continue to receive treatment.

BQH's lawyer said there was insufficient evidence to find that immediate treatment was required to prevent serious harm to BQH or another person. BQH's lawyer said that BQH's mental state had remained largely unchanged; his beliefs regarding those who had harmed him and his right to compensation remained constant despite treatment; and there was no evidence BQH had acted on any of his beliefs. The lawyer indicated that, despite BQH's unusual lifestyle, his physical health had not deteriorated. BQH was willing to accept help with his hoarding problem and for repairs to be undertaken at the house. He was also willing to stay in hospital until his treating doctor agreed he could be discharged.

The Tribunal decided there was insufficient evidence that BQH needed immediate treatment to prevent serious deterioration in his mental health because there was no clear evidence that his mental health had significantly deteriorated when treatment in the community was ceased some time ago. BQH's core beliefs remained unchanged, but he was not distressed by any of these beliefs and conceded that he would need to accept it if his compensation attempts were unsuccessful. BQH had maintained his physical health despite cooking and sleeping outside. There was no suggestion that he had engaged in self-harm or had suicidal ideas at any time. The Tribunal found that BQH's family's concern for his welfare due to his eccentric lifestyle was not sufficient to justify unwanted compulsory mental health treatment. The Tribunal also found that incurring financial loss by pursuing his claims for compensation did not amount to serious harm. The Tribunal found that there was no evidence that BQH's delusional beliefs caused him to be any risk to any other person.

Part 2
Hearing Statistics for 2017–18

Key statistics at a glance *^

	2017-18 Number	2016-17 Number	2015-16 Number
Hearings listed **	13,564	12,759	12,160
Hearings conducted	8,279	7,816	7,469
Decisions made	7,520	7,197	6,878
Adjourned	759	619	591
Treatment Orders made	6,127	5,925	5,603
TO / TTOs revoked	340	371	358
ECT Orders made	682	590	624
ECT applications refused	80	101	86
NMI hearings conducted	8	6	2
Statements of reasons requested	233	225	243
Applications to VCAT	39	33	20

Attendance at hearings

	2017-18 Number	2016-17 Number	2015-16 Number
Patients	4,751	4,709	3,992
Family members	1,464	1,313	1,088
Carers	549	422	363
Nominated persons	222	180	308
Legal representatives	1,213	1,198	1,049
Interpreters	443	290	236

* *The figures in Parts 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 2015-16 and 2016-17 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

The Tribunal gathers and reports statistics on the basis of case types, hearings and treatment orders.

A case type can be defined as the 'trigger' for a hearing. For example, an application for 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.

2.1 Treatment Orders

2.1.1 Outcomes of hearings regarding Treatment Orders

In 2017-18, the Tribunal made a total of 6,127 Treatment Orders (TOs) and revoked 340 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 (14) and 105 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.

Figure 1: ***Determinations regarding Treatment Orders***

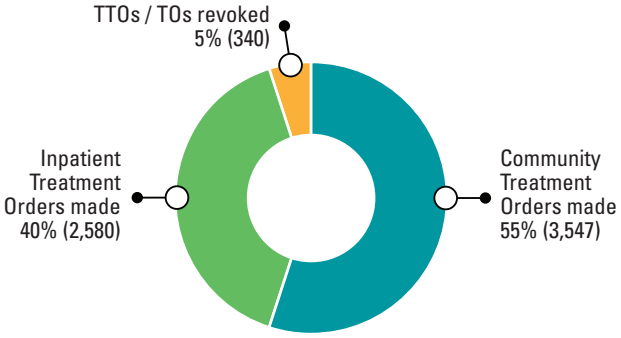


Table 1: ***Determinations regarding Treatment Orders***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**3,547**	**55%**	3,423	54%	3,121	52%
Inpatient Treatment Orders made	**2,580**	**40%**	2,502	40%	2,482	42%
TTOs / TOs revoked	**340**	**5%**	371	6%	358	6%
Total Orders made or revoked	**6,467**	**100%**	6,296	100%	5,961	100%

Figure 2: ***Duration of Community Treatment Orders made***

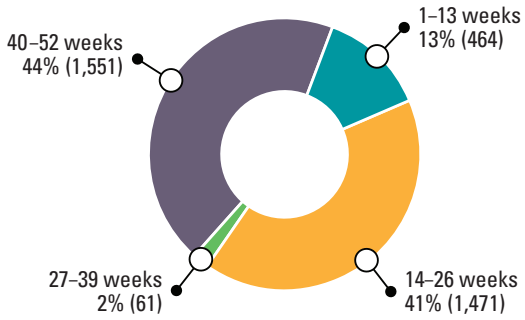


Table 2: ***Duration of Community Treatment Orders made***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
1–13 weeks	**464**	**13%**	464	13%	479	15%
14–26 weeks	**1,471**	**41%**	1,331	39%	1,192	38%
27–39 weeks	**61**	**2%**	61	2%	51	2%
40–52 weeks	**1,551**	**44%**	1,567	46%	1,399	45%
Total	**3,547**	**100%**	3,423	100%	3,121	100%

Figure 3: ***Duration of Inpatient Treatment Orders made***

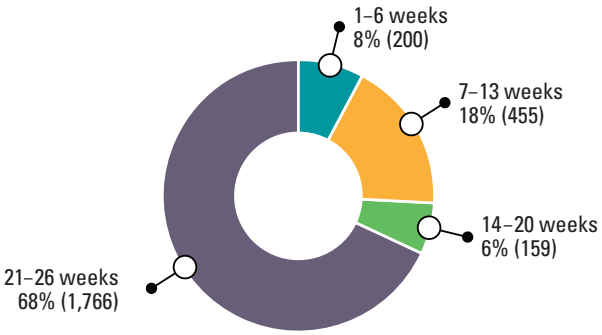


Table 3: ***Duration of Inpatient Treatment Orders made***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
1–6 weeks	**200**	**8%**	162	6%	164	6%
7–13 weeks	**455**	**18%**	490	20%	546	22%
14–20 weeks	**159**	**6%**	150	6%	168	7%
21–26 weeks	**1,766**	**68%**	1,700	68%	1,604	65%
Total	**2,580**	**100%**	2,502	100%	2,482	100%

Case Study

Making decisions: How the Tribunal determines whether a person can be treated less restrictively as a voluntary patient

The Tribunal must consider whether there is no less restrictive means reasonably available to enable the person to receive immediate treatment. 'No less restrictive' is not defined in the Mental Health Act 2014. In Treatment Order hearings, this criterion essentially requires the Tribunal to decide whether the person requires compulsory treatment or whether they can receive treatment on a voluntary basis.

In MJS [2018] VMHT 16, the hearing focused on whether MJS could be treated as a voluntary patient. MJS was diagnosed with bipolar affective disorder in 2010. She received voluntary treatment for a short time after being diagnosed, but otherwise had no contact with mental health services until early 2018 when her general practitioner became concerned about her mental state. MJS received compulsory treatment as an inpatient for approximately three weeks before her Temporary Treatment Order was revoked. However, she experienced a further relapse of her mental illness less than a week after her Temporary Treatment Order was revoked, and she was placed back onto an Inpatient Temporary Treatment Order.

At the hearing, the Tribunal observed the positive relationship MJS had with her treating team; it could tolerate points of difference and disagreement. MJS told the Tribunal her goal was to stop taking medication: she had lived with her illness for nearly a decade and had managed it without medication. She acknowledged the treating team had a different view about the timeline to ceasing medication. MJS emphasised that she knew her triggers and symptoms and knew how to live with her illness. She was willing to work with the treating team and was determined to stay out of hospital. MJS explained the impact compulsory treatment had on her. She said removing this stressor would improve her strategies for managing her illness and she would be more motivated to work with the treating team if she was a voluntary patient. MJS initiated an arrangement with her parents whereby they supervised her medication adherence and attendance at appointments. This would continue if MJS became a voluntary patient. MJS's parents told the Tribunal they were concerned about the effect the medication had on MJS, but agreed that any reduction in medication needed to be planned and gradual. They stressed that they did not think MJS needed to be a compulsory patient.

The treating team supported MJS's wish to cease medication, but thought a short Order would enable more assertive treatment to ensure MJS received treatment while she settled into a regular routine.

The Tribunal accepted that all of the parties wanted to avoid a third admission and the Tribunal was persuaded by MJS's evidence that her circumstances had changed. MJS actively involved her family in her treatment plan; she accepted that she needed treatment; and she recognised the treating team wanted her to continue with medication for a longer period than she preferred. The Tribunal considered MJS's explanation of how greater autonomy would increase her motivation to collaborate with her treating team. The Tribunal accepted voluntary treatment involved some risk, but concluded it was within the degree of risk contemplated by the principles of the Act. MJS had years of experience managing her illness, supportive family and friends, and a high level of rapport with her treating team. The Tribunal therefore decided MJS could receive immediate treatment voluntarily and revoked her Treatment Order.

2.1.2 Treatment Order hearing outcomes by initiating case type

Hearings regarding Treatment Orders can be initiated in a number of ways. The preceding graphs summarise the Tribunal's total determinations regarding Treatment Orders. The 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 4: ***Outcomes of 28 day hearings***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**1,316**	**42%**	1,229	41%	1,218	40%
Inpatient Treatment Orders made	**1,654**	**52%**	1,606	53%	1,636	54%
Temporary Treatment Orders revoked	**189**	**6%**	186	6%	196	6%
Total Treatment Orders made or revoked	**3,159**	**100%**	3,021	100%	3,050	100%

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

	2017–18	2016–17	2015–16
Treatment was able to be provided in a less restrictive manner	**77%**	59%	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	**7%**	16%	18%
Immediate treatment was not able to be provided	**12%**	14%	19%
The person did not have a mental illness	**4%**	11%	6%
Total	**100%**	100%	100%

Applications for a Treatment Order by the authorised psychiatrist

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

Table 6: ***Outcomes of authorised psychiatrist application hearings***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**2,002**	**82%**	1,926	80%	1,689	79%
Inpatient Treatment Orders made	**345**	**14%**	365	15%	338	16%
Treatment Orders revoked	**97**	**4%**	113	5%	101	5%
Total Treatment Orders made or revoked	**2,444**	**100%**	2,404	100%	2,128	100%

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

	2017–18	2016–17	2015–16
Treatment was able to be provided in a less restrictive manner	**65%**	62%	60%
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%**	19%	18%
Immediate treatment was not able to be provided	**12%**	12%	12%
The person did not have a mental illness	**5%**	7%	10%
Total	**100%**	100%	100%

Applications for revocation by or on behalf of a patient

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

Table 8: ***Outcomes of revocation hearings***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**336**	**43%**	376	45%	358	42%
Inpatient Treatment Orders made	**384**	**50%**	401	48%	417	49%
Temporary Treatment Orders / Treatment Orders revoked	**54**	**7%**	55	7%	77	9%
Total Orders made or revoked	**774**	**100%**	832	100%	852	100%

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

Table 9: ***Reasons the Tribunal revoked Temporary Treatment Orders / Treatment Orders in revocation hearings***

	2017–18	2016–17	2015–16
Treatment was able to be provided in a less restrictive manner	**76%**	46%	53%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**12%**	25%	23%
Immediate treatment was not able to be provided	**5%**	14%	17%
The person did not have a mental illness	**7%**	15%	7%
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 10: ***Outcomes of variation hearings***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**84**	**13%**	103	16%	62	11%
Inpatient Treatment Orders made	**539**	**82%**	482	77%	441	81%
Treatment Orders revoked	**36**	**5%**	45	7%	41	8%
Total Treatment Orders made or revoked	**659**	**100%**	630	100%	544	100%

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

Table 11: ***Reasons the Tribunal revoked Treatment Orders in variation hearings***

	2017–18	2016–17	2015–16
Treatment was able to be provided in a less restrictive manner	15%	9%	21%
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%	4%	7%
Immediate treatment was not able to be provided	75%	87%	63%
The person did not have a mental illness	5%	0%	9%
Total	100%	100%	100%

2.2 ECT Orders – Adults

2.2.1 Outcomes of applications for an ECT Order

In 2017-18 the MHT heard a total of 762 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.

Compulsory patients

During 2017-18, 673 ECT Orders were made for adult compulsory patients.

Voluntary patients

In March 2018 the Tribunal commenced hearing ECT applications concerning voluntary adult patients. This expansion of the Tribunal's role was pursuant to reforms introduced by the *Medical Treatment Planning and Decisions Act 2016* (see Part 1.1.2). During 2017-18, 10 applications for an ECT related to an adult being treated as a voluntary patient. Nine ECT Orders were made and one application was refused.

Figure 4: ***Determinations regarding ECT applications***

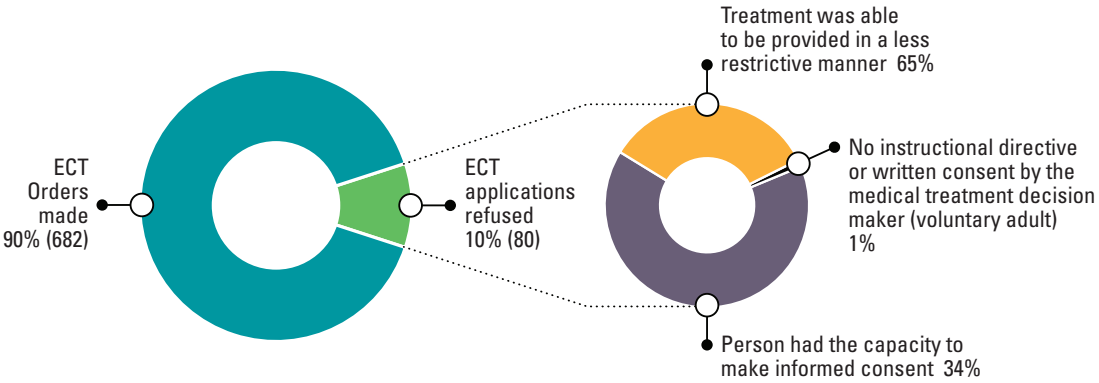


Table 12: ***Determinations regarding ECT applications***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
ECT Orders made	682	90%	590	85%	624	88%
ECT applications refused	80	10%	101	15%	86	12%
Total ECT Orders made or applications refused	762*	100%	691	100%	710	100%

**A further two ECT applications were determined as no jurisdiction, and two ECT applications were struck out*

Table 13: ***Reasons applications for an ECT Order were refused***

	2017–18	2016–17	2015–16
Treatment was able to be provided in a less restrictive manner	**65%**	55%	57%
Patient had the capacity to give informed consent	**34%**	38%	39%
Tribunal has insufficient information to make a decision	**-**	6%	4%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	**1%**	-	-
Total	**100%**	100%	100%

Figure 5: ***Duration of ECT Orders***

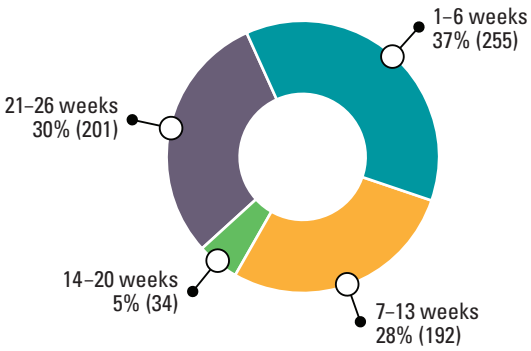


Table 14: ***Duration of ECT Orders***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
1-6 weeks	**255**	**37%**	309	52%	338	54%
7-13 weeks	**192**	**28%**	104	18%	131	21%
14-20 weeks	**34**	**5%**	29	5%	19	3%
21-26 weeks	**201**	**30%**	148	25%	136	22%
Total	**682**	**100%**	590	100%	624	100%

Figure 6: ***Number of ECT treatments authorised***

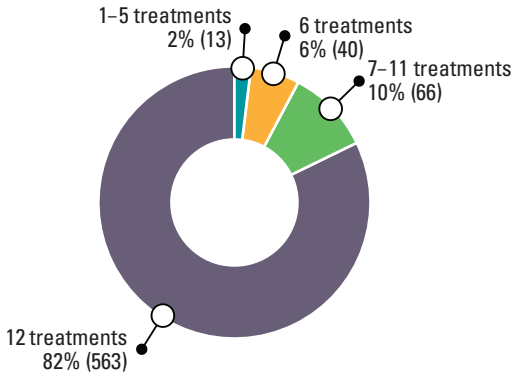


Table 15: ***Number of ECT treatments authorised***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
1-5 treatments	**13**	**2%**	13	2%	29	5%
6 treatments	**40**	**6%**	59	10%	75	12%
7-11 treatments	**66**	**10%**	122	21%	113	18%
12 treatments	**563**	**82%**	396	67%	407	65%
Total	**682**	**100%**	590	100%	624	100%

Case Study

Making decisions: How the Tribunal considers applications to treat a person with ECT

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. The Tribunal must have regard to the views and preferences of the person with respect to ECT and any alternative treatments. The Tribunal will also look at the views of the person's nominated person, guardian and/or carer. The Tribunal must also consider the likely consequence for the person if ECT is not performed and any second psychiatric opinion the person has obtained.

In JSP [2018] VMHT 18, the patient was receiving treatment for her first episode of psychosis with a probable diagnosis of schizophrenia. At the time of the hearing, JSP had been in hospital for about nine weeks but her mental state had not improved, despite trials of different antipsychotic medications. The treating team had discussed ECT with JSP at a family meeting with her sister and brother. The treating team said ECT was a less restrictive treatment option because it would provide a quicker response than alternative antipsychotic medications. A second psychiatric opinion supported ECT for JSP. At the hearing, the treating team said JSP would not discuss ECT at medical reviews other than to say she did not need ECT or medication.

JSP's lawyer said JSP did not think ECT was appropriate at present. It was her first admission and the first time she had received a psychiatric diagnosis. JSP was initially treated as a voluntary patient and was engaging with treatment. JSP told the Tribunal she was afraid of ECT and that six to 12 treatments would be too many. She preferred to have medication and go home where she could get back to her normal life. She said ECT was okay for some people, but she was scared of it because her brain was weak and could not take the current and it might electrocute her whole body. The Tribunal asked JSP about clozapine which was an alternative medication being considered by the treating team. JSP said she didn't know much about it but had been doing some reading online about ECT and was worried about memory loss. JSP's lawyer said that JSP's fear of ECT should trump the possibility of an earlier discharge. JSP's sister told the Tribunal she had seen some improvement in her sister and explained that their mother had recently returned from overseas.

The Tribunal took into account JSP's lengthy admission and the fact that this was the first time she was diagnosed with and treated for a psychiatric illness. JSP expressed a clear preference for oral medication, even if that meant her admission might be prolonged.

The treating team were considering clozapine; however, JSP and her family had not received detailed information about that treatment option. An important factor for the Tribunal was the fact that both JSP and her family did not support ECT. JSP's family were concerned about the side effects of ECT and JSP's mother had only recently returned from overseas and further discussions with her would be beneficial. JSP was not opposed to other treatment options and preferred to stay in hospital rather than receive ECT. The Tribunal therefore decided there was a less restrictive way for JSP to be treated and refused to grant the application.

2.2.2 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 working 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 made up almost 60% of applications to the Tribunal for an ECT Order.

Figure 7: ***Proportion of applications for ECT Orders that were urgent***

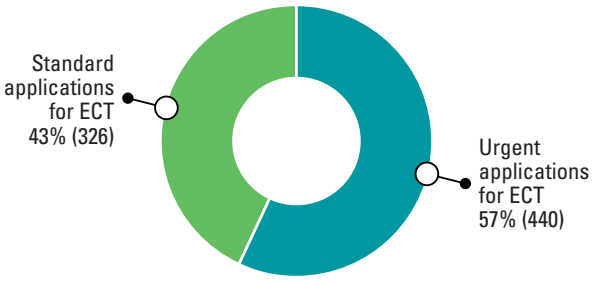


Table 16: ***Proportion of applications for ECT Orders that were urgent***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Urgent applications for ECT	**440**	**57%**	405	59%	397	56%
Standard applications for ECT	**326**	**43%**	286	41%	314	44%
Total ECT applications	**766**	**100%**	691	100%	711	100%

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. Urgent after-hours ECT hearings are conducted as a telephone conference call.

In 2017-18, the Tribunal heard seven urgent after-hours ECT applications. Six of the applications were granted, and one application was adjourned to a business day.

2.2.3 Elapsed time from receipt of ECT applications to hearing

Figure 8: ***Elapsed time from receipt of ECT applications to hearing***

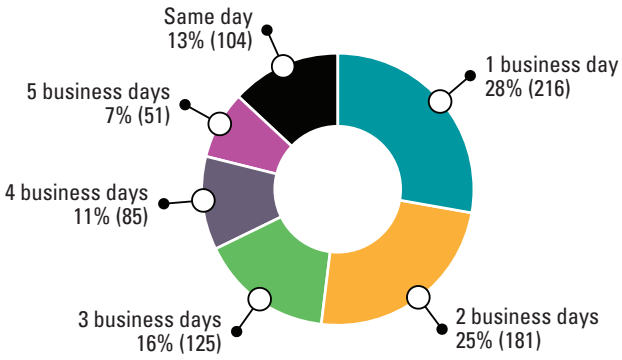


Table 17: ***Elapsed time from receipt of ECT applications to hearing***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Same day	**104**	**13%**	94	14%	140	20%
1 business day	**216**	**28%**	216	31%	215	30%
2 business days	**181**	**25%**	159	23%	152	22%
3 business days	**125**	**16%**	96	14%	92	13%
4 business days	**85**	**11%**	82	12%	74	10%
5 business days	**51**	**7%**	39	6%	35	5%
Total	**762***	**100%**	686	100%	708	100%

** Four ECT hearings were conducted out of time because of Tribunal error*

Case Study

Making decisions: How the Tribunal examines capacity in ECT hearings

In ECT hearings, the Tribunal must first consider whether the patient has capacity to give informed consent. If the patient does have capacity to give informed consent, the Tribunal must refuse the application. It must be assumed a person has capacity, unless it is demonstrated that this is not the case. The Act sets out the considerations the Tribunal must have regard to when determining whether a person has capacity to give informed consent: does the person understand the information relevant to the decision, and have the ability to remember and use or weigh that information, and are they able to communicate their decision? The Tribunal assesses these issues on a case-by-case basis and also takes into consideration the principles set out in section 68(2) of the *Mental Health Act 2014*. These include that a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered unwise, and that reasonable steps should be taken to conduct an assessment at a time and in an environment in which the person's capacity to give informed consent can be assessed most accurately. The Supreme Court of Victoria is currently considering the capacity test set out in the Act.

In MCS [2018] VMHT 5, the patient was diagnosed with schizoaffective disorder and had been known to mental health services for over 15 years. MCS's lawyer said the presumption that MCS had capacity had not been displaced because there was no evidence on the file that MCS lacked capacity. MCS gave instructions that there was something lodged behind her eye and she believed she was being monitored. MCS's lawyer said MCS had not received appropriate information about ECT so she could not make an informed decision. MCS was concerned about the side effects of ECT, particularly memory loss, and she told the Tribunal it was hard to tell whether the prescribed medication had any beneficial effects.

MCS was being treated in a high dependency unit with frequent observations due to the high risk that she would injure her eye attempting to remove what she believed was a chip implanted by government agencies.

The Tribunal said MCS had some general appreciation of the nature of ECT; however, the Tribunal found MCS was unable to understand and use or weigh the information given to her to make an informed decision. The Tribunal did not accept the legal submission that the treating team had failed to provide sufficiently detailed information to MCS. The Tribunal noted the treating team had had multiple conversations with MCS regarding the treatment plan and had given her detailed written information. However, MCS's core delusional belief was of such intensity that she was only able to turn her mind to how she could remove the chip. The Tribunal therefore decided that MCS did not have capacity to give informed consent.

In UFZ [2018] VMHT 21, the patient had a diagnosis of schizoaffective disorder, poly-substance misuse disorder and an intellectual disability. UFZ said he didn't want ECT and wanted to leave hospital. He said he didn't want to read any more information about ECT because it took too long, but he might be interested to learn more about it. He wanted to speak to his sister about ECT because she had had ECT in the past. UFZ's lawyer said the Tribunal was unable to make a finding that UFZ did not have capacity to give informed consent because the presumption had not been displaced; UFZ had not been given adequate information or a reasonable opportunity to make an informed decision; and the information was not given to him in a way that was suitable for his learning style. A neuropsychological assessment conducted prior to the hearing indicated that UFZ had a low processing speed and difficulty learning new information in large amounts, which he needed to have broken down. UFZ's father said it may be productive for UFZ to have a little longer to think about ECT. The treating team said UFZ's poor memory and cognitive function prevented him from absorbing information about ECT; they did not think lack of time was an issue because the main barrier was getting UFZ to stay and listen to the information. However, the treating team acknowledged it would be useful for UFZ to talk to his sister about ECT.

In this case, the Tribunal was not satisfied UFZ did not have capacity to give informed consent. The Tribunal found that UFZ had not been given a reasonable opportunity to make an informed decision about ECT. The Tribunal also had regard to section 68(2)(e) of the Act, which requires assessments of capacity to be conducted at a time and in an environment where the person's capacity can be assessed most accurately.

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

Compulsory patients

During 2017-18, one application for an ECT Order was received relating to a compulsory patient under 18 years of age. The patient was 13 years old and the application was granted.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2017-18, the Tribunal received no applications for an ECT Order related to a young person being treated as a voluntary patient.

Table 18: ***Determinations regarding young person ECT applications***

	2017-18	2016-17	2015-16
	No.	No.	No.
Compulsory patients			
ECT Order made			
Patient's age: 13	**1**	0	0
Patient's age: 16	**0**	0	3
Patient's age: 17	**0**	0	3
Voluntary patients			
ECT Order made			
Patient's age: 15	**0**	0	3
Patient's age: 17	**0**	2	1
Application refused			
Patient's age: 17	**0**	1	0
Total	**1**	3	10

2.4 Neurosurgery for mental illness

During 2017-2018, the Tribunal received eight applications to perform neurosurgery for mental illness (NMI). All eight applications were granted.

Table 19: ***Number and outcomes of applications to perform NMI***

Application	Applicant mental health service	Diagnosis	Proposed Treatment	Location of patient	Hearing outcome
1	Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	WA	Granted
2	Neuropsychiatry John Cade Building, Royal Melbourne Hospital	Obsessive compulsive disorder	Deep brain stimulation	VIC	Granted
3	Neuropsychiatry John Cade Building, Royal Melbourne Hospital	Obsessive compulsive disorder	Deep brain stimulation	NSW	Granted
4	St Vincent's Hospital	Obsessive compulsive disorder	Deep brain stimulation	VIC	Granted
5	St Vincent's Hospital	Obsessive compulsive disorder	Deep brain stimulation	VIC	Granted
6	Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	VIC	Granted
7	Alfred Psychiatry Research Centre	Depression	Deep brain stimulation	VIC	Granted
8	Neuropsychiatry John Cade Building, Royal Melbourne Hospital	Obsessive compulsive disorder	Deep brain stimulation	VIC	Granted

2.5 Security patients

During 2017-18, the Tribunal made 83 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

Table 20: ***Determinations made in relation to security patients by case type***

	2017-18	2016-17	2015-16
	No.	No.	No.
Hearings for a security patient			
28 day review			
Remain a security patient	**69**	59	61
Discharge as a security patient	**2**	6	1
Six month review			
Remain a security patient	**6**	9	13
Discharge as a security patient	**0**	0	1
Application for revocation by or on behalf of the patient			
Remain a security patient	**3**	4	4
Applications struck out	**3**	0	0
Total hearings for a security patient	**83**	78	80
Application by a security patient regarding leave			
Applications granted	**0**	0	0
Applications refused	**0**	0	1
Total applications by a security patient regarding leave	**0**	0	1

2.6 Applications to review the transfer of patient to another service

During 2017-18, the Tribunal received five applications to review the transfer of a patient to another health service.

Table 21: ***Number and outcomes of applications to review transfer of patient to another service***

	2017-18	2016-17	2015-16
Applications granted	**1**	0	0
Applications refused	**4**	5	4
Applications struck out	**0**	1	0
No jurisdiction	**0**	1	1
Total	**5**	7	5

2.7 Applications to transfer a patient interstate

During 2017-18 there was one application received by the Tribunal to transfer a patient interstate. The application was refused.

Table 22: Number and outcomes of applications to transfer a patient interstate

	2017-18	2016-17	2015-16
Applications granted	**0**	1	0
Applications refused	**1**	0	0
Applications struck out	**0**	0	0
No jurisdiction	**0**	0	0
Total	**1**	1	0

2.8 Applications to deny access to documents

During 2017-18, the Tribunal received 72 applications to deny access to documents.

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

	2017-18	2016-17	2015-16
Applications granted	54	39	35
Applications refused	16	10	2
Applications struck out	1	0	2
No jurisdiction	1	0	0
Total	72	49	39

2.9 Applications for review by VCAT

During the year, 39 applications were made to VCAT for a review of a Tribunal decision.

Table 24: ***Applications to VCAT and their status***

	2017-18	2016-17	2015-16
Applications made	39	33	20
Applications withdrawn	18	14	12
Applications struck out	0	2	1
Applications dismissed	1	1	0
Hearings vacated	0	0	1
Decision set aside by consent	1	9	6
Applications proceeded to full hearing and determination	13	1	0
Applications pending at 30 June	6	6	0

Table 25: ***Outcomes of applications determined by VCAT***

	2017-18	2016-17	2015-16
Decisions affirmed	13	6	5
Decisions varied	0	1	0
Decision set aside and another decision made in substitution	0	1	0
Orders revoked	0	1	1

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 maximum of ten business days, and the Tribunal must not extend the Order more than once.

The reasons for the Tribunal concluding that exceptional circumstances justified an adjournment that extended a patient's Order are collated under three categories: procedural fairness (including to enable participation of the patient or other relevant persons in the hearing), to enable legal representation, and where the mental health service was not ready to proceed with the hearing.

Figure 9: ***Hearings adjourned***

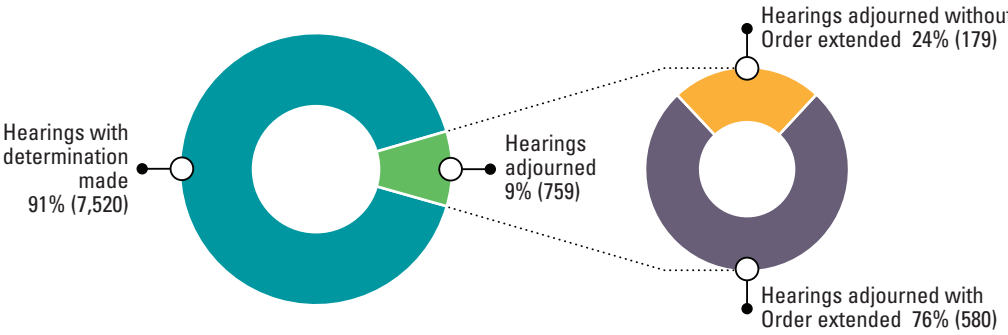


Table 26: ***Hearings adjourned***

	2017-18		2016-17		2015-16	
	No.	%	No.	%	No.	%
Hearings adjourned without Order extended	**179**	**24%**	152	25%	173	29%
Hearings adjourned with Order extended	**580**	**76%**	467	75%	418	71%
Total hearings adjourned	**759**	**100%**	619	100%	591	100%
Total hearings adjourned as a percentage of total hearings conducted	**9%**		8%		8%	

Figure 10: ***Reasons for adjournments with extension of Order***

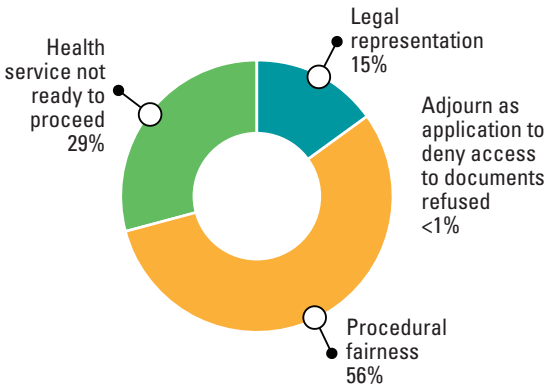


Table 27: ***Reasons for adjournments with extension of Order***

	2017-18	2016-17	2015-16
Procedural fairness	**56%**	57%	54%
Health service not ready to proceed	**29%**	23%	29%
Legal representation	**15%**	20%	17%
Adjourn as application to deny access to documents refused	**< 1%**	< 1%	0%
Total	**100%**	100%	100%

2.11 Attendance and legal representation at hearings

Part 3 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, the patient's parent if they are under the age of 16, the authorised psychiatrist and the following persons if applicable:

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

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

Table 28: ***Number and percentage of hearings with the patients and support people in attendance***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Patient	**4,752**	**57%**	4,709	60%	3,984	58%
Carer	**549**	**7%**	422	5%	362	5%
Family member	**1,464**	**18%**	1,313	17%	1,084	16%
Nominated person	**222**	**3%**	180	2%	308	4%
Interpreter	**443**	**5%**	290	4%	236	3%
Legal representative	**1,211**	**15%**	1,198	15%	1,048	15%
Total hearings conducted *	**8,279**	**–**	7,816	–	–	–
Total hearings determined*	**–**	**–**	–	–	6,878	–

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

Legal representation at hearings

As noted in Part 1, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the number of patients who were legally represented at a hearing in 2017-18.

Table 29: ***Legal representation at hearings***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
Victoria Legal Aid	**1,063**	**13%**	1,059	14%	922	13%
Mental Health Legal Centre	**95**	**1%**	80	1%	73	1%
Private Lawyer	**39**	**1%**	39	< 1%	36	1%
Other Community Legal Centre	**14**	**<1%**	20	< 1%	18	< 1%
Total legal representation	**1,211**	**15%**	1,198	15%	1,049	15%
Total hearings conducted *	**8,279**	**–**	7,816	–	–	–
Total hearings determined *	**–**	**–**	–	–	6,878	–

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

2.12 Patient diagnoses

In preparing their reports for the Tribunal, treating doctors note the primary diagnosis of the patient. The list of diagnoses presented in the table below is the indicative percentage of the primary diagnosis of patients who had Tribunal hearings in 2017-18.

Table 30: ***Primary diagnoses of patients who had Tribunal hearings***

	2017-18	2016-17	2015-16
Schizophrenia	47%	47%	47%
Schizo-Affective disorder	22%	21%	26%
Bipolar disorder	10%	10%	11%
Depressive disorders	4%	4%	3%
Delusional disorder	2%	2%	2%
Dementia	1%	1%	1%
No diagnosis recorded	3%	5%	1%
Other organic disorders	< 1%	< 1%	< 1%
Eating disorders	1%	1%	< 1%
Other	10%	9%	9%
Total	100%	100%	100%

2.13 Mode of conducting hearings

As discussed in Part 1, while the Tribunal prefers to conduct hearings in person, it is not always possible to do so. In 2017-18, less than one quarter of hearings were conducted via video conference.

Table 31: ***Hearings conducted by mode***

	2017–18		2016–17		2015–16	
	No.	%	No.	%	No.	%
In-person	6,269	76%	5,964	76%	5,507	74%
Video conference	2,006	24%	1,835	24%	1,958	26%
Teleconference	10 *	< 1%	25 *	< 1%	13	< 1%
Totals hearings conducted #	8,285	100%	7,824	100%	7,478	100%

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

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

2.14 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.

2.14.1 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 2017-18, there were seven matters where a hearing was not conducted before a patient's Order expired. In each instance, the Tribunal found that the substantive Order had expired and therefore did not have jurisdiction to conduct a hearing. Each of these matters had been listed out of time due to Tribunal error.

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 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.

In 2017-18, 21 variation hearings were conducted more than 28 days after the variation of the Order. In one case, the cause was because of a Tribunal error. In five 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 15 of these cases, the Tribunal adjourned the hearing beyond the 28 day time limit. It did so knowing that the hearing would occur outside the statutory timeline but for the reason that proceeding with the hearing on the day would have been unfair to the patient.

Additionally, a further four ECT hearings were conducted out of time because of Tribunal error.

2.14.2 **Customer service**

The Tribunal's Service Charter is published on our website, and outlines the service standards people can expect from the staff of the Tribunal. These standards include that the Tribunal will answer 90% of phone calls within 15 seconds, and respond to email enquiries within 2 business days, unless the enquiry is complex and/or requires investigation and cannot be fully responded to within 2 business days.

In 2017-18, the Tribunal responded to 95% of phone calls within 15 seconds, and responded to all email and website enquiries in accordance with the Service Charter.

The Tribunal's KPI for sending Treatment and ECT Orders is within five business days of the hearing. In 2017-18, we achieved this target 54% of the time.

Table 32: ***Sending Treatment and ECT Orders*** *#*

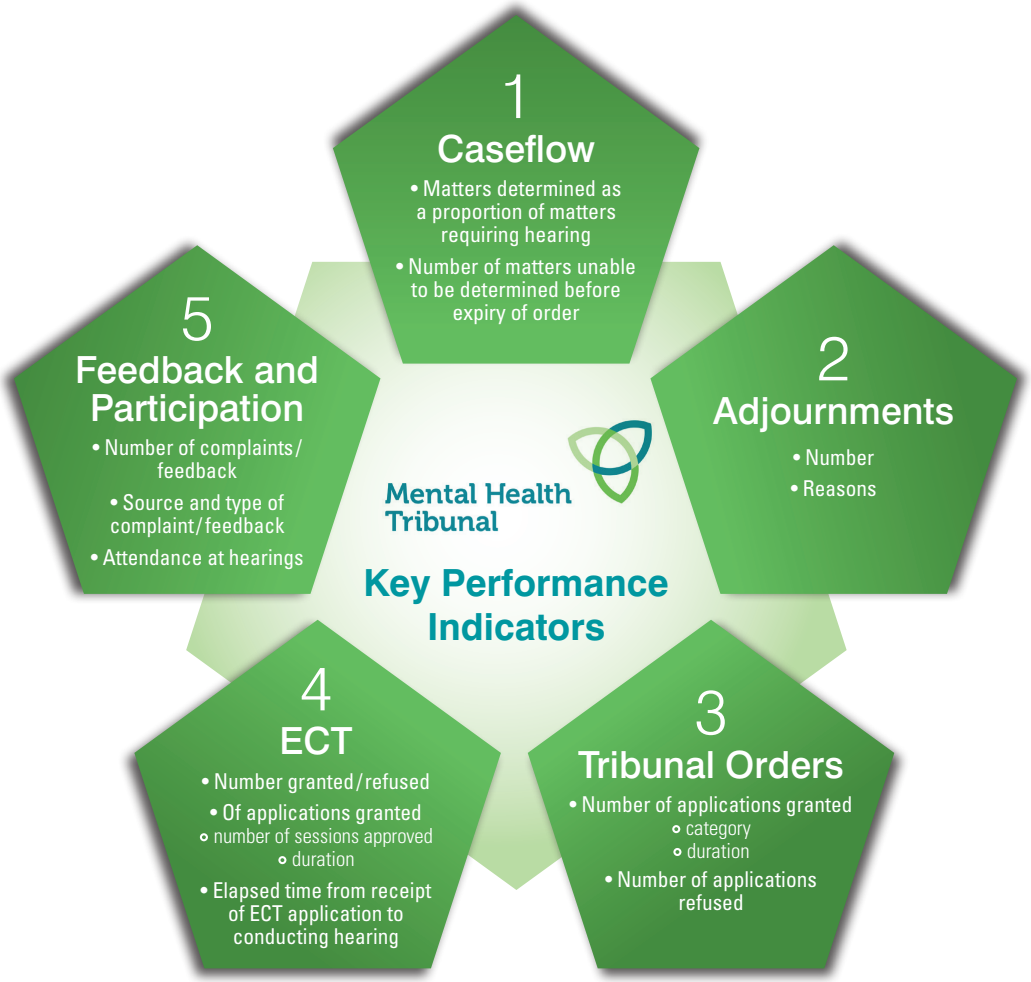
	2017-18	2016-17	2015-16
	%	%	%
Percentage of Orders sent to parties within five working days of a hearing	**54%**	59%	80%
	Number	Number	Number
Average number of days to send Order to parties	**6**	6	4

 # The Tribunal's Registry aims to send Treatment and ECT Orders to relevant parties within five working days of a hearing. This is the first year the Tribunal has reported this measure.

2.15 Key Performance Indicators

The Tribunal monitors its performance against Key Performance Indicators (KPIs). KPI reports are published quarterly, and are available on our website.

Figure 11: ***Mental Health Tribunal KPIs***



Case Study

Making decisions: How the Tribunal determines the duration of a Treatment Order

The Act does not provide guidelines or criteria for determining the duration of a Treatment Order; it only sets the maximum duration. The Tribunal considers each matter on a case-by-case basis and makes a decision based on the patient's needs and circumstances.

In AQY [2018] VMHT 3, the treating team recommended a 52-week Community Treatment Order. AQY had been recently diagnosed with schizoaffective disorder due to the length of time it took for his mental state to settle after he had ceased illicit drug use. The treating team said AQY's mental state did not settle in the absence of illicit drug use and had deteriorated further when he was on the ward, requiring a course of ECT. The treating team said a 52-week Order would facilitate consistent medication, allow stability to be reintroduced into AQY's lifestyle and hopefully foster a therapeutic alliance.

Instead, the Tribunal made a Community Treatment Order for 12 weeks. The Tribunal recognised that an earlier division of the Tribunal had made an Order of 52-weeks duration, but AQY had not attended the earlier hearing.

On this occasion, the Tribunal was concerned that there was a lack of clarity regarding AQY's diagnosis. The Tribunal also had regard to the fact that the treating team had questioned whether AQY was experiencing psychotic symptoms or if he was simply angry, and that AQY's parents also questioned the diagnosis. There was also evidence that AQY may be experiencing some cognitive deficit and that a neuropsychiatric assessment was appropriate. Given there was diagnostic uncertainty and AQY's mental state was improving, the Tribunal said it would be unnecessarily restrictive for AQY to be subject to an Order for 52 weeks. The Tribunal said a 12-week Order would provide sufficient time for the treating team to clarify AQY's diagnosis and noted that the treating team could make a further application for a Treatment Order if they believed AQY required further compulsory treatment.

In HEC [2018] VMHT 1, the patient was diagnosed with substance-induced psychosis with a differential diagnosis of schizophrenia. HEC gave evidence that he had worked at many stressful jobs over the years and had been using synthetic cannabis to self-medicate for depression. He wanted to move back interstate where he had not previously come into contact with illicit drugs and he put most of his problems down to boredom. He said he had intended to use small amounts of synthetic cannabis to get a euphoric feeling, but had used too much. HEC said that until recently, he had not understood psychosis and the need for treatment and he was concerned that taking medication might affect his job prospects; however, his attitude had changed as he recovered. He said that at the time of his previous discharge from hospital, he was released into the same stressful environment that led to his admission and that his decision to go interstate would help to change that. He believed that he needed to stay engaged with treatment, get a job and study, and take medication in order to stay well.

The treating team said HEC was still in the early stages of recovery. They were concerned that without a Treatment Order, HEC would resume illicit drug use and disengage from the service, leading to a deterioration in his mental health. On this basis, the treating team recommended a 26-week Community Treatment Order, which would ensure HEC received treatment for a significant period of time to allow him to recover from his serious psychotic episode. It would also provide time for him to move interstate and engage with a new treating team. The treating team were concerned that if the Tribunal made a short Order, it would send the wrong message to the interstate receiving service.

HEC's lawyer said a short Order was appropriate. The Tribunal agreed and made an eight-week Community Treatment Order. The Tribunal said this would allow HEC to meet and be assessed by his new interstate treating team, and it would give the new treating team time to make an application for a further Treatment Order, if that was necessary. The Tribunal emphasised that the short duration did not imply that HEC has not had a significant illness or that he will not need treatment for a considerable time. Rather, the nature and circumstances of that treatment and whether it can be voluntary treatment are best decided where HEC will be living and receiving treatment.

Where a patient makes an application for revocation of an Order, the Tribunal is mindful not to be seen as penalising them for exercising their right to make an application or dissuading them from making a future application by making a longer Treatment Order. This was illustrated in OPS [2017] VMHT 43 where OPS applied to the Tribunal to revoke his Community Treatment Order.

OPS had a diagnosis of schizoaffective disorder and a history of psychiatric treatment dating back to the 1990s. The treating team recommended that OPS remain on his existing 52-week Community Treatment Order. The treating team said this would facilitate ongoing review in the community and follow-up of his adherence to medication and regular administration of depot medication. It would also prevent disengagement with treatment and allow early management of any relapse.

The Tribunal had serious concerns about OPS's level of insight and acceptance of the need to remain on treatment. The Tribunal agreed with the concerns raised by the treating team that OPS required a sustained period of treatment and that his adherence to treatment was likely to be low in the absence of an Order. While the Tribunal agreed that a lengthy Order was necessary, the Tribunal was mindful that OPS had initiated the application to revoke his Treatment Order and the Tribunal did not want to deter him from doing so again by imposing a longer Treatment Order. The Tribunal therefore made a 42-week Order to preserve the expiry date of the previous Treatment Order.

Part 3
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 principles focus on least restrictive treatment and promote recovery and full participation in community life. Among other things, they emphasise that consumers should be involved in all decisions about their treatment and recovery and supported to make, or participate in, decisions. The principles state that the rights, dignity and autonomy of persons receiving mental health services should be respected and promoted.

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.

The Tribunal's commitment to upholding these principles in our hearing and administrative functions is reflected in our vision, which is that the principles and objectives of the *Mental Health Act 2014* are reflected in the experience of consumers and carers. It is reinforced by our mission, which commits us to focusing in our hearings on human rights, least restrictive treatment and the participation of consumers, carers and clinicians.

Flowing from our vision and mission, the strategic priorities set out in our Strategic Plan for the next three years (2018-2020) include the following:

- Ensuring fair, consistent and solution-focused hearings that engage participants as active partners in the Tribunal's decision-making process. This involves participants discussing, identifying and committing to actions or solutions to optimise recovery
- Promoting the realisation of the principles and objectives of the Act.

This part of the Annual Report 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, as well as the principles around involving, recognising, respecting and supporting carers.

This part also provides brief updates on projects described in last year's Annual Report, highlights our new initiatives, and foreshadows projects we expect to commence or complete during 2019-20.

Mental Health Tribunal
Strategic Plan 2018-2020

Our Vision
That the principles and objectives of the *Mental Health Act 2014* are reflected in the experience of consumers and carers.

Our Mission
The Mental Health Tribunal decides whether a person receives compulsory treatment under the *Mental Health Act 2014*. Our hearings focus on human rights, least restrictive treatment and the participation of consumers, carers and clinicians.

Our Values
We are:
- **Collaborative**
- **Fair**
- **Respectful**
- **Recovery Focused.**

Our Strategic Priorities

1 Ensuring fair, consistent and solution focused hearings

Fairness in our hearings and in the way we engage with participants is a core obligation of the Tribunal. Solution focused hearings engage participants as active partners in the Tribunal's decision-making process. This involves participants discussing, identifying and committing to actions or solutions to optimise recovery.

Over the life of this plan the Tribunal will:
- Implement a Tribunal Member Feedback Model to enable members to reflect on how they approach their role
- Adhere to a strategic approach to meeting the ongoing learning and development needs of Tribunal members and staff
- Review the size and structure of the Tribunal's membership to identify optimal arrangements for the future; and
- Survey participants' experience of Tribunal hearings to identify opportunities for improvement.

Our focus for 2018:
- Finalise and commence the roll-out of our Tribunal Member Feedback Model
- Undertake internal quantitative and qualitative analysis of future options for the size and structure of the Tribunal membership; and
- Implement our Experience of Tribunal Hearings survey.

2 Promoting the realisation of the principles and objectives of the *Mental Health Act 2014*

All entities and individuals working under the *Mental Health Act 2014* ('the Act') have a shared responsibility to adhere to and promote the mental health principles and the objectives of the Act.

Over the life of this plan the Tribunal will:
- Enhance the Tribunal's approach to liaison with health services
- Continue to explore the implications of the principles of the Act for Tribunal processes and decision-making, including through consultation with consumers and carers; and
- Critically reflect on our own operation and contribute to analysis and review of the operation of the Act.

Our focus for 2018:
- Engage with health services to develop a strategy to build and maintain understanding of the role of the Tribunal and effective participation in hearings
- In consultation with consumers and carers, explore strategies to encourage and facilitate participation in hearings by family, carers and other support people; and
- Commence preliminary research into the Tribunal's approach to setting the duration of Treatment Orders.

3 Using technology to make our processes more efficient and sustainable

The Tribunal's processes have been significantly modernised over the past three years but continue to be heavily paper-based and do not make full use of the opportunities available through better use of technology.

Over the life of this plan the Tribunal will:
- Improve Tribunal business processes using information technology, including electronic hearing document management
- Transition to TRIM Electronic Records Management for the Tribunal's administrative documents; and
- Develop a new website for the Tribunal to improve user experiences.

Our focus for 2018:
- Review how our Registry and administrative processes are supported by information technology and implement opportunities for improvement
- Scope a project to develop a new website for the Tribunal; and
- Transition to the TRIM Electronic Document and Records Management System.

Mental Health Tribunal

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.

Tribunal Advisory Group

The Tribunal Advisory Group (TAG) consists of consumers, carers, peer workers and senior Tribunal staff. Throughout 2017-18, the TAG continued to provide strategic and operational advice to the Tribunal and coproduced key initiatives in support of maximising the participation of consumers and carers.

In October 2017, the TAG coproduced our second Consumer and Carer Forum with the theme *'We're listening: improving the Tribunal hearing experience for consumers, their carers and family members'*. This forum included a presentation by Dr Peter McKenzie (Carer Academic, Family Practice Consultant and Clinical Family Therapist at the Bouverie Centre) on family inclusive practice and a panel discussion with Dr McKenzie, Tribunal members and TAG members. The 2017 panel discussion summary and forum evaluation survey results are available on our website.

Other activities undertaken by the TAG this year included:

- completing the Tribunal's *Consumer and Carer Experience of Hearings* survey pilot, which validated the survey tool
- co-authoring a new webpage 'What to expect at my Mental Health Tribunal hearing'
- presenting on consumer leadership at the Victorian Mental Illness Awareness Council (VMIAC) Conference
- continuing to advise the Tribunal on website content and resources and templates that will assist consumers and carers in navigating Tribunal hearings.

TAG activities for next year include:

- contributing to the development of a new Tribunal website
- assisting with the full implementation of the *Consumer and Carer Experience of Hearings* survey.

Consumer and carer participation in Member recruitment

The CEOs of the Victorian Mental Illness Awareness Council (VMIAC) and Tandem, the respective peak bodies for consumers and carers, were members of the selection panels for the recent Tribunal Member appointment round. Both CEOs gave six days of their time to undertake this important role, providing a very valuable and independent consumer and carer focus to the interview process.

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; rather, it recognises 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 are key players in formulating and implementing plans to address the underlying issues that have led to their participation in the process.

Accordingly, solution-focused hearings complement and reflect the mental health principles set down by the Act. In particular, they contribute to the best possible therapeutic outcomes and promote recovery and full participation in community life. In addition, they are an important way to involve consumers in decisions about their treatment and recovery, and to support them to make, or participate in, those decisions. Solution-focused hearings respect consumers' rights, dignity and autonomy, but also seek to involve carers in hearings whenever possible and to recognise, respect and support the role of carers.

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). The guide was intended to be a starting point in the development of a comprehensive framework to govern how the Tribunal performs its functions and approaches its decision-making. In last year's Annual Report, the Tribunal reported that we had 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 and are sensitive to the particular issues that might arise for these groups of consumers.

We have continued to develop the Guide this year, with work focusing on exploring the Tribunal's role in the treatment space and enhancing the participation of carers and family members in hearings.

Exploring the Tribunal's role in the treatment space

In 2017-18, we continued to explore the Tribunal's role in treatment issues, culminating in the publication of a new chapter of the Guide titled *'Constructive inquiry, clarification and reflection – the role of the Mental Health Tribunal in relation to treatment'*. Among other things, the chapter notes that exploration and promotion of the Act's mental health principles inherently requires scrutiny of the current treatment a patient is receiving and future treatment plans.

For example, the chapter explains that without a clear picture regarding current and proposed treatment, it is not possible to ensure the treatment is the least restrictive possible, recovery-oriented and focused on supported decision-making. The chapter also recognises that the practical implications of the principle of dignity of risk can only be understood if the degree of risk is clearly articulated and the link to the proposed treatment is clear. Finally, the chapter notes that treatment plans must be framed around an individual and their circumstances – including, but extending beyond, the specific symptoms of their mental illness – to ensure that 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. This chapter is available on the Tribunal's website.

Promoting the participation of carers and family members in Tribunal hearings

The Tribunal is exploring ways to improve the participation of family and carers in hearings and plans to release a new chapter on this subject in 2018-19. The chapter will explore how the Tribunal and health services can deal with common obstacles to carer participation at all stages of the hearing process. The chapter will clarify the relevant legal framework, but the main focus will be on providing all hearing participants with a coherent framework and practical strategies for encouraging and facilitating participation in Tribunal hearings by carers and family.

We are delighted that Dr Peter McKenzie, mentioned in part 3.1 above, has agreed to share his considerable expertise by contributing to the chapter, particularly in relation to strategies and communication techniques, based on his extensive experience in conducting single session family conferences.

The Tribunal's ongoing work in this space highlights our strong commitment to aligning hearings with the mental health principles related to involving carers (including children who are carers) in decisions about treatment and recovery, and recognising, respecting and supporting the role of carers.

Case Study

Making decisions: How the Tribunal achieves a solution-focused approach

A solution-focused approach recognises that a unique series of experiences and events precedes a person being a compulsory patient at a particular point in time – and that if they are willing or wish to explain some of those circumstances, it is relevant and important for them to have the opportunity to do so.

A solution-focused approach also challenges everyone to remember that compulsory treatment should never be regarded as an ongoing norm for any individual. Where possible, a pathway to less restriction and greater autonomy for the person should be explored, including what voluntariness truly means in the context of each person's circumstances, taking into account that people should be allowed to make decisions that involve a degree of risk.

A solution-focused approach facilitates a process that can provide an opportunity for those involved in hearings (consumers, their support people and clinicians) to explore issues and potential strategies to address difficulties. In some cases, it may simply be about timing –seizing an opportunity that hasn't presented itself before to discuss these issues.

Two case studies illustrate this approach and how the Tribunal takes into account the views and preferences of mental health consumers.

- Rebecca* was distressed by the side effects of her antipsychotic medication, in particular, its impact on her artistic work. She was also concerned about the lack of a referral to a psychologist as part of her treatment plan and that her clinical history contained incorrect information. Rebecca's treating team asked the Tribunal to make a 12-month Community Treatment Order. Based on the discussion at the hearing where Rebecca and her treating team agreed on a strategy to address her concerns, the Tribunal made a much shorter 12-week Order, as Rebecca should be able to be treated voluntarily if these issues were resolved.
- Jacob's* treating team asked the Tribunal to make an Order that would require him to remain in hospital for at least another three weeks. Jacob was desperate to leave hospital for a number of reasons, including upcoming events that were of deep cultural significance to him and his family. The Tribunal hearing was the first occasion Jacob's mother and father had been available to participate in a meeting with Jacob and his treating team. The discussion that took place identified a collaborative strategy between Jacob, his family and treating team that meant the Tribunal made an Order allowing Jacob to be treated while living at home (and participating in the cultural events) rather than staying in hospital.

In some cases, the Tribunal can be a forum to discuss and confirm positive developments already underway. John's case illustrates that recognising progress, including having an independent body acknowledge what has been achieved, can potentially contribute to further positive outcomes.

- John* was unhappy about being on a Treatment Order, had previously had a poor relationship with his treating team and had made numerous applications to the Tribunal to revoke his Order. He had a history of not adhering to treatment and had had numerous compulsory admissions over many years. John particularly disliked depot medication (medication by injection) and had previously told the treating team that he planned to avoid this treatment by going 'on the run.'

  To avoid this scenario, the treating team and John had negotiated a new clinical treatment plan. In response to John's concerns, John and his doctors had agreed on a less intrusive plan: John would start oral medication and be supervised daily by a pharmacist or the treating team for one month; he would then take oral medication unsupervised for one month and then medication would be on an as-needed basis for a subsequent month. John agreed to consultant reviews to review side effects and the impact on his mental stability and mood, and to have ongoing contact with the community treating team.

  It was clear to the Tribunal that John was happier with this approach, which took his views and treatment preferences into account and gave him a greater degree of agency and autonomy in managing his treatment. It was also clear he had developed a good relationship with his case manager. Clearly, the new treatment plan represented a significant positive development. The Tribunal acknowledged this and recognised it was an achievement shared by both John and his treating team. Based on the discussion in the hearing, John's views changed. He had requested a hearing to have the CTO revoked, but decided that it would actually be helpful to have the Order in place while these changes were made.

  Given that John and his treating team were in agreement, the Tribunal made a CTO with a duration that aligned with the duration of the previous Treatment Order made a few weeks previously. Both John and his treating team were very happy with this outcome. John was reminded that should he change his mind again, he could make another application to have the Order revoked.

*All names changed.

3.3 Professional development of members: a focus on the Tribunal's vision and the principles of the Act

Professional development opportunities and the opportunity for individual members to reflect on their practice, the operation of the Act and the Tribunal's work generally continue to progress and develop. A key goal of the Tribunal's professional development activities is to develop members' skills in combining rigorous scrutiny of the relevant criteria with a focus on the best possible therapeutic outcomes that are solution-focused and grounded firmly in the principles of the Act.

Throughout the year, members took advantage of a number of forums, seminars and other opportunities to meet and discuss topical issues and to hear from expert speakers. Specific opportunities are also provided in the current members' professional development program for members to reflect on their individual approaches, their strengths and areas for improvement.

Members are able to observe hearings conducted by a division, allowing them to reflect on the operation of a Tribunal division of which they are not part and to consider and learn from the conduct and skills of a colleague of the same membership category. This year, the Tribunal also commenced a Member Feedback Framework, which allows individual members to reflect on their own performance by self-appraisal and to obtain feedback from other members with whom they have worked in hearings.

The Feedback Framework uses the Tribunal's competency standards as the basis for these peer and self-appraisal surveys. These standards reflect a strong focus on the Tribunal's values and on applying the principles of the Act in hearings. For example, there are a number of questions that ask about the member's knowledge of the Act and their respect for, and promotion of, key principles such as supported decision-making, autonomy and recovery. Individual members, in consultation with the President and Deputy President, are able to use the information from the peer and self-appraisal surveys to recognise strengths and areas for development, as well as to identify subjects and themes for the Tribunal's broader professional development program for members.

All of the Tribunal's professional development processes are designed to support members to conduct hearings where consumers and their families and carers actively participate and their views and preferences (including their recovery goals) are heard and taken into account.

3.4 Promoting the mental health principles: revamped education sessions for health services

Another way in which the Tribunal is embedding the mental health principles in its work is through education sessions for health service staff.

The Tribunal has provided ad hoc education and information sessions since its commencement in 2014, but now proactively invites all health services to engage with our education sessions. Our aim is to deliver an education session on the role of the Tribunal and how to best prepare for and engage with hearings at all health services at least once each year.

Sessions include information about the Tribunal itself, the inquisitorial process, solution-focused hearings, the treatment report, the role of legal representatives and access to documents.

An important part of the presentations concerns the practical and cultural changes ushered in by the Act, emphasising that the Tribunal is not the Mental Health Review Board with a new name. The mental health principles are central to this discussion.

The Tribunal has been given the task of deciding whether to make Treatment Orders. The Act directs the Tribunal to proceed in a way that protects and safeguards people's rights and gives people agency in a process that affects them intimately. The Tribunal does this by conducting hearings in a way that promotes the involvement of participants, observing and implementing the mental health principles.

The participants in Tribunal hearings, and the Tribunal itself, have different perspectives on the mental health principles and their meaning or implications in individual situations. Hearings are an opportunity to share, explore and better understand these different perspectives. Our education sessions are designed to 'lay the ground work' for these discussions. In these sessions, we emphasise that the discussion in hearings needs to extend beyond what might be needed to keep someone well to include promoting rights, dignity and autonomy and making decisions about assessment, treatment and recovery that involve a degree of risk. In doing so, our education sessions are intended to promote a richer hearing experience for all participants.

Case Study

Making decisions: Exploration of the mental health principles in statements of reasons

In preparing statements of reasons under the Act, the Tribunal aims to write primarily for the consumer. This involves using plain language, avoiding the use of jargon and minimising references to case law. It also involves ensuring that the views and preferences of consumers and their family members and carers are reflected in the reasons.

Clear and transparent 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 also play a role in recording obstacles that may be affecting a person's progress along the pathway towards less restrictive treatment and in highlighting the next steps and actions needed to move towards less restrictive and, ultimately, voluntary treatment.

The hearings that gave rise to the statements of reasons set out below illustrate how the Tribunal incorporates the mental health principles in its decision-making process, particularly by focusing on the best possible therapeutic outcomes and promoting the rights, dignity and autonomy of consumers. Perhaps most importantly, they show how the Tribunal involves consumers and their carers as active participants in its decision-making process and how their participation influences the Tribunal's ultimate decision.

DJJ [2018] VMHT 17 – Tribunal facilitated discussion about wider issues affecting the patient's care and recovery

In the hearing regarding DJJ, as well as considering whether the criteria for compulsory treatment were met, the Tribunal facilitated a discussion between DJJ, her guardian and her treating team about the issues affecting her care and recovery, which the Tribunal summarised as follows:

> 'Discussions regarding recovery and solutions for DJJ
>
> The Tribunal is satisfied that the criteria for compulsory treatment were met for DJJ. During the hearing this was largely accepted and not controversial. It was clear that everyone involved in DJJ's care was concerned that DJJ had been unwell for some time and that she had not responded to the treatment provided during the most recent hospital admissions.
>
> The Tribunal attempts to conduct hearings in a way that ensures that all participants are heard and this often means that hearings can become a forum for discussions around treatment, the patient's needs and preferences, the perspectives of the patient's family and friends, future options for care and treatment and barriers to the patient's recovery. DJJ's hearing became one where the focus was on DJJ's future treatment and needs – concerns and complexities were canvassed clearly and respectfully, and all participants were focused on DJJ's recovery.
>
> At the hearing DJJ's family members discussed their dissatisfaction with the poor communication they had experienced, concerns regarding some specific aspects of DJJ's care and their lack of confidence in the treating team. For example, they provided background information and explained that as DJJ had been a victim of abuse, she reacted adversely to restraint and lacked trust in persons she was not familiar with. DJJ's family offered some guidance as to how to encourage DJJ's adherence to treatment.
>
> During the hearing DJJ's doctor also had an opportunity to respond to specific medication and nursing issues raised by DJJ's family and provided his perspective on some of the complexities around DJJ's health and treatment during her recent admissions.
>
> The Tribunal encouraged the treating team and DJJ's family and friends to resolve issues around communication. Hopefully a single point of communication could be established to avoid further difficulties. This should improve outcomes for DJJ. The referral to the dual disability service was seen as constructive by everyone at the hearing.'

Having regard to these issues and others, the Tribunal decided to make a Treatment Order for a duration that was considerably less than the treating team's recommendation. The Tribunal noted that DJJ had accepted and received treatment for many years previously without the need for a Treatment Order and it hoped that, once her mental state was more stable, she would once again be able to be treated voluntarily. The Tribunal also stated that a Treatment Order with a shorter duration allows oversight by the Tribunal, concluding:

> 'If there is a further application for a Treatment Order, the Tribunal will be in a position to further engage in a solution-focused hearing process that would include consideration of DJJ's diagnosis (following input from other services), treatment planning, and communication between the treating team, DJJ and her legally appointed guardian and powers of attorney.'

LDC [2018] VMHT 002 – Tribunal takes principles into account in determining there was no less restrictive way for the patient to be treated

The Tribunal's decision in LDC, a hearing of an ECT application, also highlights how the Tribunal took the mental health principles and objectives and the *Charter of Human Rights and Responsibilities Act 2006* (the Charter) into account in reaching a conclusion that there was a less restrictive way for the patient to be treated. After setting out those objectives referring to the least possible restriction on human rights and dignity, promotion of recovery and involving people in decisions about their treatment and recovery and a related Charter right, the Tribunal noted:

> 'Because administering ECT without consent encroaches on the right not to be subjected to medical treatment without full, free and informed consent, decisions regarding compulsory ECT cannot be taken lightly.'

In this case, LDC objected to ECT but the Tribunal decided he did not have capacity to give informed consent to the treatment. In considering whether there was a less restrictive way for LDC to be treated, the Tribunal considered the gravity of encroaching on LDC's rights by giving him a treatment (ECT) to which he objected. It noted it is important to bear in mind that LDC's preferences are a relevant consideration even when the Tribunal is satisfied that a person does not have capacity to give informed consent to ECT. In this case, the Tribunal highlighted the Act's emphasis on the protection of individual rights and least restrictive treatment as a key reason why it considered there was a less restrictive means of treating LDC. As the Tribunal put it:

> 'The members of the treating team were undoubtedly dedicated to providing as much support for LDC as possible and if the Act were couched in terms of permitting ECT in the best interests of the individual concerned, then perhaps it would be warranted. But the current Act is based on the protection and promotion of individual rights and least restrictive treatment. Acting in the best interests of the person is not the legal test the Tribunal must apply.
>
> The Tribunal therefore decided there was presently a less restrictive way for LDC to be treated that accorded with LDC's views and preferences, which was by persevering with his medication regime rather than commencing a course of ECT.'

3.5 Tribunal research project: duration of Orders

A Tribunal research project currently underway 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. In 2016, the Tribunal explored this aspect of its decision-making by setting up a research working group (RWG) comprised of Tribunal members and staff.

The RWG began exploring how the Tribunal decides the duration of Treatment Orders 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 has focused 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?

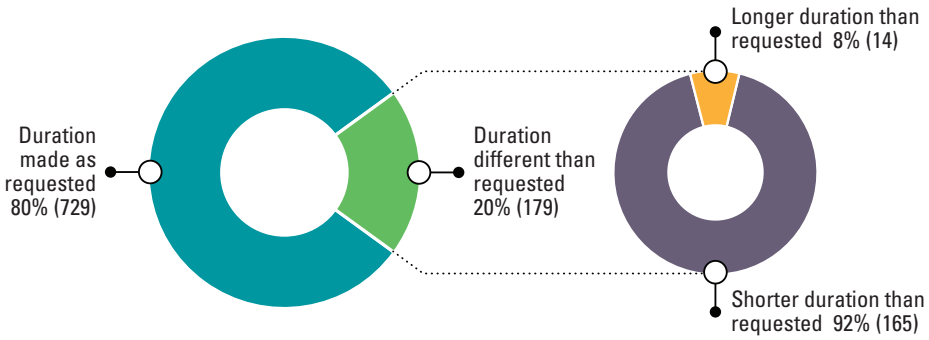
To answer the second question, the RWG considered various factors regularly identified by divisions of the Tribunal when making decisions about duration of Treatment Orders and grouped them into four main categories:

1. insufficient information for care and risk assessment;
2. parties' presentation;
3. congruence with principles of the Act; and
4. oversight required by the Tribunal.

The RWG then surveyed each Tribunal division over a period of eight weeks in 2017 to gather data for its investigation.

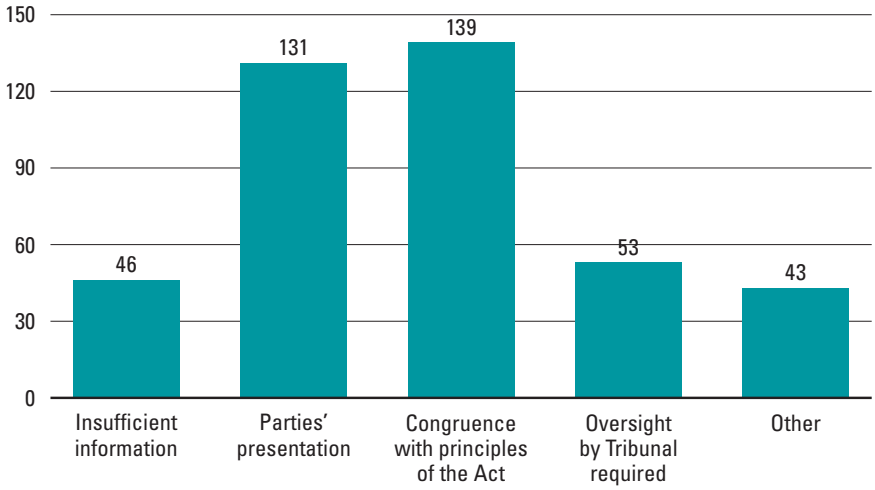
In this period, the Tribunal made a total of 908 Treatment Orders. As shown in the figure below, of those Orders, around one in five (n 179) were made with a duration that was different than requested: 92% (n 165) of these Orders were shorter than requested and 8% (n 14) were longer than requested.

Figure 12: ***Tribunal decisions on duration of Treatment Orders – 8 week study***



Regarding the factors or considerations being taken into account when making these decisions, the most commonly cited reason was congruence with principles of the Act. The second most common was the parties' presentation at the hearing (that is, information provided by one or more participants).

Figure 13: ***Factors in deciding different Treatment Order duration for hearings***



Of the 179 hearings where the duration of the Order made by the Tribunal was different than requested, 75% (n 135) were attended by the patient, 35% (n 62) were attended by a support person of the patient, and in 28% the patient had a legal representative.

Table 33: ***Select attendance statistics for Order duration study***

Attendance where a Treatment Order was made	No.	%
Patient	597	66%
Legal representative	154	17%
Other support person	234	26%
Total hearings where a Treatment Order was made	908	–

Attendance where the Order duration was different than requested	No.	%
Patient	135	75%
Legal representative	50	28%
Other support person	62	35%
Consultant	39	22%
Medical officer	155	87%
Case manager	87	49%
Total hearings where the Order duration was different than requested	179	–

The Tribunal hopes 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.

Appendix A

Financial Management Compliance Attestation Statement and Summary

Financial Management Compliance Attestation Statement

I, Jan Dundon, on behalf of the Mental Health Tribunal, certify that the Mental Health Tribunal has complied with the applicable Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and its Instructions.

Jan Dundon
Executive Officer

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

Funding sources and expenditure

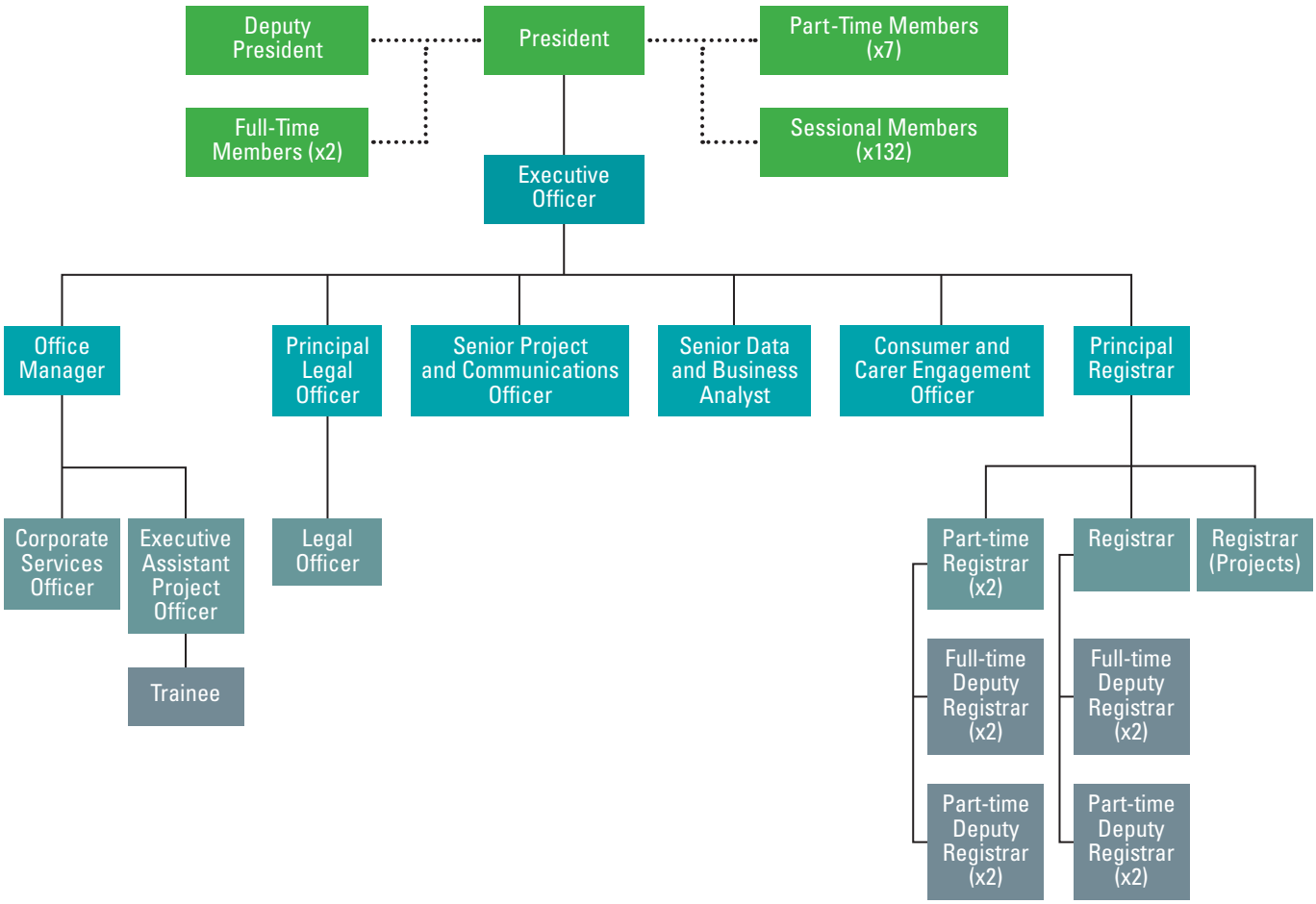
The Tribunal receives a government appropriation directly from the Department of Health and Human Services.

APPROPRIATION	**2017-2018**	2016-2017	2015-2016
TOTAL	**$ 9,640,663**	$ 8,249,445	$ 8,109,551

EXPENDITURE			
Full and part-time member salaries	**$ 1,559,784**	$ 1,308,120	$ 1,343,608
Sessional member salaries	**$ 4,413,473**	$ 3,792,832	$ 3,260,481
Staff Salaries (includes contractors)	**$ 1,624,924**	$ 1,576,658	$ 1,875,774
Total Salaries	**$ 7,598,191**	$ 6,677,610	$ 6,479,866
Salary On costs	**$ 1,217,943**	$ 1,090,767	$ 1,078,171
Operating Expenses	**$ 653,266**	$ 486,944	$ 548,733
TOTAL	**$ 9,469,400**	$ 8,255,321	$ 8,106,767
Balance	**$ 171,263**	-$ 5,876	$ 2,784

Appendix B

Organisational Chart as at 30 June 2018



Appendix C

Membership List as at 30 June 2018

Full-Time Members	Period of Appointment
President	
Mr Matthew Carroll	1 June 2003 – 1 June 2020 *(Appointed President 23 May 2010)*
Deputy President	
Ms Troy Barty	1 June 2003 – 9 June 2023 *(Appointed Deputy President 15 March 2017)*
Senior Legal Members (Full-time)	
Ms Emma Montgomery	25 Aug 2014 – 9 June 2023
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 2023
Mr Graham Rodda	10 June 2018 – 9 June 2023

Sessional Members	Period of Appointment
Legal Members	
Mr Darryl Annett	25 Feb 2016 – 24 Feb 2021
Ms Wendy Boddison	7 Sept 2004 – 9 June 2023
Ms Venetia Bombas	10 June 2013 – 9 June 2023
Ms Meghan Butterfield	10 June 2018 – 9 June 2023
Mr Andrew Carson	3 Sept 1996 – 9 June 2023
Mr Robert Daly	10 June 2013 – 9 June 2023
Ms Arna Delle-Vergini	10 June 2018 – 9 June 2023
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 2023
Ms Tamara Hamilton-Noy	25 Feb 2016 – 24 Feb 2021
Mr Jeremy Harper	10 June 2008 – 9 June 2023
Ms Amanda Hurst	10 June 2013 – 9 June 2023
Ms Kylie Lightman	10 June 2013 – 9 June 2023
Ms Jo-Anne Mazzeo	10 June 2013 – 9 June 2023
Ms Carmel Morfuni	25 Feb 2006 – 24 Feb 2021
Ms Alison Murphy	25 Feb 2016 – 24 Feb 2021
Mr David Risstrom	25 Feb 2006 – 24 Feb 2021
Ms Janice Slattery	25 Feb 2006 – 24 Feb 2021
Ms Susan Tait	10 June 2013 – 9 June 2023
Dr Michelle Taylor-Sands	10 June 2013 – 9 June 2023
Mr Christopher Thwaites	10 June 2018 – 9 June 2023
Dr Andrea Treble	23 July 1996 – 24 Feb 2021
Ms Helen Versey	10 June 2013 – 9 June 2023
Mr Stuart Webb	10 June 2018 – 9 June 2023
Ms Jennifer Williams	7 Sept 2004 – 9 June 2023
Dr Bethia Wilson	10 June 2013 – 9 June 2023
Ms Tania Wolff	10 June 2018 – 9 June 2023
Ms Camille Woodward	25 Feb 2011 – 24 Feb 2021
Prof Spencer Zifcak	8 Sept 1987 – 24 Feb 2021

Sessional Members	Period of Appointment
Psychiatrist Members	
Dr Peter Adams	10 June 2018 – 9 June 2023
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 2023
Dr Joe Black	11 March 2014 – 9 June 2023
Prof Sidney Bloch	14 July 2009 – 9 June 2023
Dr Ruth Borenstein	10 June 2018 – 9 June 2023
Dr Pia Brous	10 June 2008 – 9 June 2023
Dr Peter Burnett	10 June 2018 – 9 June 2023
Dr Robert Chazan	25 Feb 2016 – 24 Feb 2021
Dr Peter Churven	10 June 2018 – 9 June 2023
Dr Eamonn Cooke	14 July 2009 – 9 June 2023
Dr Blair Currie	9 Oct 2012 – 24 Feb 2021
Dr Elizabeth Delaney	25 Feb 2011 – 24 Feb 2021
Dr Leon Fail	9 Oct 2012 – 24 Feb 2021
Assoc Prof John Fielding	11 March 2014 – 9 June 2023
Dr Joanne Fitz-Gerald	25 Feb 2016 – 24 Feb 2021
Dr Stanley Gold	10 June 2008 – 9 June 2023
Dr Fintan Harte	13 Feb 2007 – 24 Feb 2021
Assoc Prof Anne Hassett	11 March 2014 – 9 June 2023
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 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 2023
Dr Stella Kwong	29 June 1999 – 24 Feb 2021
Dr Jennifer Lawrence	9 Oct 2012 – 24 Feb 2021
Dr Sheryl Lawson	10 June 2018 – 9 June 2023
Dr Grant Lester	11 March 2014 – 9 June 2023
Dr Margaret Lush	3 Sept 1996 – 9 June 2023
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 2023
Dr Michael McCausland	10 June 2018 – 9 June 2023
Dr Cristea Mileshkin	14 July 2009 – 9 June 2023
Dr Peter Millington	30 Oct 2001 – 9 June 2023
Dr Frances Minson	30 Oct 2001 – 9 June 2023
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 2023
Dr Philip Price	10 June 2018 – 9 June 2023
Dr Philip Roy	09 Oct 2012 – 24 Feb 2021
Dr Amanda Rynie	25 Feb 2016 – 24 Feb 2021
Dr Sudeep Saraf	25 Feb 2016 – 24 Feb 2021
Dr Rosemary Schwarz	25 Feb 2016 – 24 Feb 2021
Dr Joanna Selman	11 March 2014 – 9 June 2023
Dr John Serry	14 July 2009 – 9 June 2023
Dr Anthony Sheehan	10 June 2008 – 9 June 2023
Dr Robert Shields	10 June 2018 – 9 June 2023
Dr Jennifer Torr	11 March 2014 – 9 June 2023
Dr Maria Triglia	25 Feb 2011 – 24 Feb 2021
Assoc Prof Ruth Vine	9 Oct 2012 – 24 Feb 2021
Dr Susan Weigall	10 June 2018 – 9 June 2023

Sessional Members	Period of Appointment
Registered Medical Members	
Dr Anthony Barnes	10 June 2018 – 9 June 2023
Dr Trish Buckeridge	1 July 2014 – 9 June 2023
Dr Louise Buckle	1 July 2014 – 9 June 2023
Dr Kaye Ferguson	25 Feb 2016 – 24 Feb 2021
Dr Naomi Hayman	1 July 2014 – 9 June 2023
Dr John Hodgson	1 July 2014 – 9 June 2023
Dr Helen McKenzie	1 July 2014 – 9 June 2023
Dr Sharon Monagle	1 July 2014 – 9 June 2023
Dr Sandra Neate	25 Feb 2016 – 24 Feb 2021
Dr Debbie Owies	1 July 2014 – 9 June 2023
Dr Stathis Papaioannou	1 July 2014 – 9 June 2023
Community Members	
Assoc Prof Lisa Brophy	10 June 2008 – 9 June 2023
Mr Duncan Cameron	10 June 2008 – 9 June 2023
Dr Leslie Cannold	10 June 2013 – 9 June 2023
Ms Katrina Clarke	10 June 2018 – 9 June 2023
Ms Paula Davey	29 Oct 2014 – 9 June 2023
Ms Robyn Duff	25 Feb 2011 – 24 Feb 2021
Ms Sara Duncan	10 June 2013 – 9 June 2023
Ms Angela Eeles	10 June 2018 – 9 June 2023
Mr Bernard Geary	10 June 2018 – 9 June 2023
Ms Jacqueline Gibson	10 June 2018 – 9 June 2023
Mr John Griffin	25 Feb 2011 – 24 Feb 2021
Prof Margaret Hamilton	25 Feb 2016 – 24 Feb 2021
Mr Ben Ilsley	10 June 2013 – 9 June 2023
Ms Erandathie Jayakody	10 June 2018 – 9 June 2023
Mr John King	1 June 2003 – 24 Feb 2021
Ms Danielle Le Brocq	10 June 2013 – 9 June 2023
Mr John Leatherland	25 Feb 2011 – 24 Feb 2021
Dr David List	25 Feb 2006 – 24 Feb 2021
Ms Anne Mahon	10 June 2013 – 9 June 2023
Assoc Prof Marilyn McMahon	19 Dec 1995 – 24 Feb 2021
Dr Kylie McShane	29 June 1999 – 24 Feb 2021
Ms Sarah Muling	25 Feb 2016 – 24 Feb 2021
Dr Patricia Mehegan	10 June 2008 – 9 June 2023
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 Linda Rainsford	10 June 2013 – 9 June 2023
Ms Lynne Ruggiero	10 June 2013 – 9 June 2023
Mr Fionn Skiotis	25 Feb 2006 – 24 Feb 2021
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 2023
Mr Anthony Stratford	10 June 2018 – 9 June 2023
Dr Penny Webster	25 Feb 2006 – 24 Feb 2021
Prof Penelope Weller	10 June 2013 – 9 June 2023

Appendix D
Compliance reports

In 2017-18, 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 seven of the requests, the information that was the subject of the request was information that related to the applicant's hearings with either the Tribunal or the former Mental Health Review Board; accordingly, the Tribunal released the documents administratively. Two of the requests were withdrawn and one request was handled as a formal FOI 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 ($28.90 from 1 July 2018). 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 2017-18 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.

Mental Health Tribunal

Level 30, 570 Bourke Street Melbourne Victoria 3000

Phone: (03) 9032 3200
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