Mental Health Tribunal

Annual Report 2018–**2019**

Protecting the rights and dignity of people with mental illness

Mental Health Tribunal

Mental Health Tribunal
Annual Report
2018-2019

Mental Health
Tribunal

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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 2018 to 30 June 2019.

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

This annual report covering the Mental Health Tribunal's fifth year of operation is being released into an environment dominated by the commencement of the Royal Commission into Victoria's Mental Health System. This extraordinary and potentially far-reaching development is one that we could not have imagined 12 months ago, let alone back in 2014 when the Tribunal began operating.

Before commenting on the Royal Commission, I want to highlight a number of achievements over what has been, in some respects, a 'coming of age' period at the Tribunal. In previous years we have reported on things we were planning to do, as well as initiatives that had been underway for quite some time but not completed. This year, it is gratifying to report tangible outcomes and achievements.

After thorough and incredibly rich consultation with consumers and carers, in May the Tribunal launched its new website. Any website is a reflection of the time at which it was developed and this was particularly true of the Tribunal's original website. In 2014, there was so much new information to share and only a short period of time to put it together. In our effort to tell everyone everything, we sometimes failed to ensure that information was as clear and accessible as it needed to be. Our new website is more focused and pared-back and, while all the vital information is still there, the stewardship of the Tribunal Advisory Group (TAG) and direct consultation with consumers and carers has transformed it into a far more accessible and welcoming site.

It is also especially significant to have completed the first run of the Tribunal Hearing Experience Survey, the results of which are available on our website and summarised in Part Three of this report. This initiative has provided – and will continue to provide – invaluable insight into our hearing practices. Of all the advice and direction provided by the TAG, the survey has been a particular focus, and rightly so. A body such as the Tribunal can only be credible in its claim to promote the rights of consumers and carers if we seek direct feedback on how we are doing. I am pleased to confirm we will be repeating the survey next year and looking at ways to expand its reach in order to explore the reasons many people choose not to attend their hearings.

The Tribunal has continued to develop its suite of resources designed to promote both the efficiency and effectiveness of hearings and explain our approach to all potential hearing participants: consumers, carers and clinicians. Activities over the past year include:

- expansion of the Tribunal's solution-focused hearing framework to include resources and strategies designed to promote the effective participation of families and support people. As well as drawing on solution-focused hearing principles, the experience of Tribunal members and input from the TAG, Tandem and VMIAC, the new chapter of the framework employs principles from the Client-centred Framework for Involving Families, particularly Single Session Family Consultations (SSFCs), developed by the Bouverie Centre, Victoria's Family Institute
- publication of Guidelines for ECT Hearings, which reflect the implications of the landmark Supreme Court decision in PBU & NJE v Mental Health Tribunal [2018] VSC 564 and address a range of procedural and substantive questions that regularly arise in ECT applications. The guidelines emphasise that capacity assessments must not be an evaluation of the decision a person wants to make, but only their ability to make it; that people can change their minds and this doesn't mean they lack capacity; and the significance of a person's subjective experience of ECT when deciding whether it is the least restrictive treatment in the circumstances. The guidelines also explain how the Tribunal lists ECT hearings, including changes we have implemented to maximise the amount of time consumers and support people have to prepare for a hearing and seek advice. These changes have meant that between January and June 2019 only 13 applications were listed on the day of receipt compared to 39 between July and December 2018 (a drop of 67%).

None of the initiatives described in this report could have been achieved without the TAG. Some would never have been thought of in the first instance; others might have been thought of and pursued, but the end results would not be close to those achieved in partnership with the TAG. Over the past four years, 11 consumers, carers and lived experience workforce members have been TAG members. I thank each one of them for their contribution. The Tribunal also looks forward to welcoming new TAG members in the coming year.

I also acknowledge and thank the Tribunal's highly committed and skilled members and staff who, in another year of significantly increasing caseloads, have continued to not only manage our core business, but also contribute to a variety of broader initiatives. Of particular note this year has been everyone's enthusiasm for and commitment to the Tribunal's engagement with the Royal Commission.

It is a phrase that can at times border on cliché, but the Royal Commission is truly 'a once-in-a-generation' opportunity to reimagine Victoria's mental health system, and the Tribunal is committed to engaging with its processes. As part of the mental health system, we anticipate that we may be subject to examination by the Royal Commission and we welcome that scrutiny. In addition, based on the thousands of hearings we have conducted over the past five years, the Tribunal

has a unique and privileged insight into the experiences of mental health consumers who receive compulsory treatment through Victoria's clinical mental health services, as well as the experiences of the families and friends who support them. We see many positive stories of recovery and examples of effective, collaborative treatment. However, far too often we observe how the mental health system fails to provide the treatment and support that people both need and want.

Our work also brings us into daily contact with the highly committed clinical and administrative staff working within the mental health system. Despite the enormous pressures associated with crushing caseloads and increasing demand, they strive to support consumers and carers. But the reality is that the system in which they work is neither equipped nor structured to enable staff to always provide the best possible care.

Frequently, we observe fragmented service provision that directly impacts the quality of treatment and support provided to individuals. This can also have profound impacts on the levels of restriction to which individuals are subject and the adequacy of service responses to people with complex needs. Tragically, the response to individuals with complex needs highlights the reality that in some cases, there are no truly satisfactory responses available within the current system.

The Royal Commission is sure to identify numerous consequences of the profound gulf between the level of demand for treatment and support, and the level of resources provided to services to meet that demand. The Tribunal's view is that one such consequence is the relative lack of impact of the *Mental Health Act 2014* on the level of compulsory treatment in Victoria. Resource constraints can also lead to the Act being used as a tool to decide how to allocate scare resources. This can give rise to inequality of access to services across voluntary and compulsory patients, and the illogical allocation of resources. It can position compulsory interventions under the Act as a response that 'mops up' after a crisis has occurred, when the Act envisages such interventions being used to prevent crises from occurring.

The Tribunal hopes that in addition to addressing resourcing issues, the Royal Commission will be a catalyst for rebuilding the culture of mental health service delivery, which arguably has been eroded by years of operating without adequate resources. The mental health system of the future needs to be sustainable and capable of continued evolution so it can respond to the changing needs and expectations of consumers and carers. To achieve this aim, it must be underpinned by a culture of patient-focused, empathic service delivery that is consistent across all its constituent parts, robust and proactively monitored. That culture can be articulated now, and steps taken to begin to embed it so that there is solid foundation in place to support the service system that emerges from the recommendations of the Royal Commission.

Matthew Carroll
President

Membership changes during 2018-19

Over the course of 2018-19, three members retired. Beyond sitting on hearings, members contribute to the Tribunal in a variety of ways.

We acknowledge the contribution of and say farewell to:

Legal Member:
David Risstrom

Psychiatrist Members:
Assoc Prof Anne Hassett
Dr Cristea Mileshkin

Introduction to the Mental Health Tribunal

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 s.153 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.

CASE STUDY

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

The criterion for making a Treatment Order requires the Tribunal to consider whether a person needs immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to themselves or another person. The *Mental Health Act 2014* (the Act) does not define the term 'serious deterioration'. The Tribunal explored the meaning of 'serious deterioration' and examined what is reasonable risk in RAA [2019] VMHT 10.

RAA acknowledged that when she was unwell she had thoughts that she was being followed and monitored and heard voices. RAA believed her symptoms lasted for a short time before slowly diminishing. RAA said she hadn't had the thoughts or fears for a few years and wasn't hearing voices at the time of the hearing, but she was concerned about being forced to take medication all the time because of the side effects she experienced. If it was up to RAA she would stop taking medication but would continue to check in with her treating team and would ask for help if she became unwell.

RAA had a history of drug use but she had recently reduced this. RAA was supported by friends at the hearing who said she was usually a happy and active person but when she was taking medication she was unmotivated. RAA's friends said they knew when she was getting unwell, had brought her into hospital in the past when she was unwell and would support her to get treatment if she became unwell in the future.

The treating team said RAA needed ongoing depot medication to prevent relapses in the future, although they acknowledged the side effects she experienced. The treating team was concerned that in the past RAA had increased her drug use and stopped her medication after her Treatment Order was revoked and several months later had required compulsory treatment again.

The Tribunal had regard to the objectives and principles of the Act, in particular that people receiving mental health services should be allowed to make decisions about their treatment that involve a degree of risk; that they should be involved in decisions about their treatment and be supported to make, or participate in, those decisions, and their views and preferences should be respected; and that treatment should be provided in the least restrictive way with voluntary treatment preferred.

The Tribunal accepted that RAA's mental health had deteriorated on several occasions when she stopped her medication, but it also accepted that there were several times when her mental health remained relatively stable in the absence of treatment. In addition, the Tribunal was satisfied that serious deteriorations in RAA's mental health had often taken a considerable time after she stopped taking her medication. The Tribunal was also satisfied that RAA's family and friends were aware of her symptoms and would ensure she received treatment if she became unwell again.

The Tribunal recognised RAA's decision to not receive immediate treatment involved a degree of risk, however the Tribunal decided those risks could be managed and the degree of risk was reasonable in the circumstances. The Tribunal also accepted that the principles and objectives of the Act require that in such circumstances those risks should be responded to differently. Accordingly, the Tribunal revoked RAA's Treatment 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 s. 273 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 Community Safety that enables a person to be transferred from a prison or other place of confinement to a designated mental health service where they will be detained and treated. Pursuant to s. 279 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.

CASE STUDY

Capacity to give informed consent to ECT: How the Tribunal decides a person has the ability to use or weigh information relevant to their decision.

In November 2018, the Victorian Supreme Court clarified how the ECT provisions of the *Mental Health Act 2014* should be interpreted and applied in the decision of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (PBU & NJE). The judgment confirmed that the capacity test is a functional test with a relatively low threshold, and insight and the presence of symptoms, while relevant considerations when assessing capacity, are not determinative of whether or not a person lacks capacity. In two recent decisions the Tribunal has applied the principles articulated in *PBU & NJE* when deciding whether the patient had the ability to use or weigh relevant information about ECT.

In EBJ [2019] VMHT 12, the central issue was whether EBJ could use or weigh information relevant to her decision about ECT. EBJ was admitted to hospital after expressing grandiose and religious ideas in public. During her admission, she was highly agitated and threatening and was responding to internal stimuli. She refused to engage in conversations about ECT, threatened to shoot anyone who gave her ECT and denied she was unwell.

The treating team said EBJ did not believe she was unwell and was unable to use or weigh the benefits of ECT. However, EBJ's lawyer submitted that EBJ had capacity and said there was insufficient evidence to rebut the presumption of capacity. She referred to *PBU & NJE* and submitted that EBJ did not need to carefully consider ECT and other treatment options, it was enough that she understood the general nature, purpose and effect of the treatment. She submitted that while EBJ's symptoms might make it more difficult, EBJ was able to use or weigh information and did not need to make a rational, well-balanced decision.

EBJ said she wanted to move on with her life and was prepared to remain in hospital until her medication was increased. She had previously had ECT but feared having it again because it had changed her life and now she was forgetful. EBJ said her experience of ECT was 'still traumatic'.

In its decision, the Tribunal referred to *PBU & NJE* and said that a person who is experiencing delusions may be able to use or weigh relevant information so the capacity assessment needs to look at the relationship between the delusion and the ability to use or weigh the relevant information. EBJ remained symptomatic but was able to consider the treatment options and explain her preferences. She understood what ECT was and why the treating team were recommending it, but she did not want it and appreciated that this might mean a longer hospital admission, and she expressed her preference for that over ECT. The Tribunal said EBJ's understanding and recollection of her symptoms and how ECT had previously assisted her was not perfect, but consistent with the principles outlined in PBU & NJE, insight into a person's illness and the need for treatment is not the only consideration when assessing capacity. EBJ may have been making an unwise decision, preferring more restrictive treatment or less than optimal treatment, but she was entitled to do that. The Tribunal therefore concluded that EBJ was able to use or weigh information relevant to the decision.

In IIN [2019] VMHT 16, the 'use or weigh' domain of capacity was also central to the Tribunal's decision. However, in this case the Tribunal decided IIN didn't have the ability to use or weigh relevant information and therefore she didn't have capacity to give informed consent to ECT.

IIN was admitted to hospital expressing unusual thoughts and fears a few days after she stopped taking her medications. IIN's medications were restarted but her thoughts and fears continued despite receiving treatment. At times she refused to eat, was not sleeping and her physical health was deteriorating. The day before the hearing, IIN was at times so scared that she hid under her bed.

IIN had previously had ECT and during some of her discussions with the treating team about ECT she reportedly said that in the past ECT was a factor which helped her recover and leave hospital. IIN's family thought ECT was beneficial and noted that IIN hadn't been hospitalised for several years after her last course of ECT.

During the hearing IIN expressed a lot of beliefs including her belief that she was God. The Tribunal found it difficult to follow what IIN was saying because she was talking very quickly and what she said seemed jumbled. IIN was distressed and cried as she spoke, particularly when she explained her fear that she would lose her special knowledge and wouldn't be able to share her message if she had ECT. IIN's treating team thought this reasoning indicated she did not have capacity to give informed consent to ECT.

The Tribunal accepted that IIN was extremely distressed and overwhelmed by her thoughts and fears. The Tribunal was also satisfied that IIN's concerns about memory loss were largely driven by her thoughts and fears that ECT would lead to her losing her special knowledge that she felt obliged to share. The Tribunal decided IIN's fear was so strong and significant that it meant she was unable to consider the treatment options available to her. The Tribunal therefore decided that IIN was unable to use or weigh relevant information and consequently she didn't have capacity to give informed consent to ECT.

1.1.3 Neurosurgery for mental illness (NMI)

Neurosurgery for mental illness is defined by s. 3 of the Act to include:

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

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

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

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

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

If the Tribunal grants an application, the applicant psychiatrist must provide progress reports to the Chief Psychiatrist regarding the results of the neurosurgical procedure.

1.2 Administrative procedures

1.2.1 Scheduling of hearings

The responsibility for scheduling hearings rests with the Tribunal's Registry, who use 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.

In January 2019, the Tribunal implemented new listing practices for cases that have a 28-day listing requirement (e.g. Temporary Treatment Orders (TTO) and Treatment Orders (TO) varied from community to inpatient). Previously, the Tribunal received notice of these cases from the health service seven days after the trigger event (Day 7) and a hearing date was allocated on Day 8. Under that practice, many patients and carers would be advised of a hearing only to have their hearing cancelled one or two days later because the TTO was revoked or the TO was varied back to community. From January 2019, the Tribunal changed its listing practice to wait until Day 11 before allocating a hearing date. This change has reduced the number of notifications sent by the Tribunal to patients and other parties who ultimately do not need a Tribunal hearing.

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 at the health service 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 8,600 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 consumers, carers, health services and other interested parties. These information products are available on the Tribunal's website. The Tribunal's website also links to other relevant websites; for example, the Office of the Mental Health Complaints Commissioner.

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

1.3 Conducting hearings

1.3.1 Divisions

The Act requires the Tribunal to sit as a division of three members.

A general division of the Tribunal can hear and determine all matters within the jurisdiction of the Tribunal except those relating to 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.

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 Two.

1.3.4 Determinations and Orders

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

If an Order is made, within five working days from the hearing the Tribunal's Registry will process and record the determination and 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 s.198 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.

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 has Rules governing essential aspects of its operation, accompanied by eight Practice Notes. Practice Notes deal with:

- the form of applications, clinical reports and attendance requirements
- 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
- observers at Mental Health Tribunal hearings
- access to documents prior to Tribunal hearings, including the process to be followed where an authorised psychiatrist applies to withhold documents.

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

CASE STUDY

Determining the duration of a Treatment Order

The *Mental Health Act 2014* (the Act) does not provide guidelines or criteria for determining the duration of a Treatment Order. The Tribunal considers each matter on a case-by-case basis and decides the duration based on the patient's circumstances. Some factors the Tribunal routinely considers are: the current and proposed treatment (including any planned changes in treatment), how long it's likely to take for the patient's mental health to stabilise with treatment and how long it's expected to take to transition to voluntary treatment, and the patient's psychiatric history, including history of adherence to treatment.

In QZJ [2018] VMHT 22 the Tribunal made a short five-week Community Treatment Order, instead of a 52-week Order as recommended by the treating team. In reaching this decision, the Tribunal had regard to the objectives and principles in the Act that persons receiving treatment should be provided with treatment in the least restrictive way with voluntary treatment preferred, that treatment should be provided with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and that the persons views and preferences should be respected.

The Tribunal also had regard to the principles of procedural fairness – that decisions are based on relevant information which supports the conclusions reached. In this case, the Tribunal wasn't satisfied that the members of the treating team at the hearing knew QZJ sufficiently well to provide enough cogent evidence to justify a longer Order. QZJ's mental health was improving but his last review was one month before the hearing and a more recent medical review would have provided important information about the stage of his recovery.

The treating team also failed to present a detailed treatment plan to justify a longer Order. Instead, they planned to transfer QZJ to another area mental health service, at which time the new health service would reassess and decide on QZJ's treatment plan. QZJ objected to this plan. He wanted to pursue private medical treatment and drug counselling, he was about to go back to work and wanted to look for rental accommodation in his current area, but these plans would be disrupted if his treatment was transferred to a new service.

Finally, the Tribunal was mindful that there was considerable disagreement between QZJ and his treating team about his diagnosis, and the therapeutic relationship was at risk of breaking down. The Tribunal acknowledged it was not its role to get involved in specific treatment decisions, however the Tribunal was satisfied the level of conflict between QZJ and his treating team over his diagnosis, mode and location of treatment supported the making of a shorter Order.

In IDQ [2018] VMHT 23, the Tribunal made a 26-week Community Treatment Order. The treating team recommended a 52-week Order because IDQ's illness was long-standing and difficult to treat and he had a chronic lack of insight. However, IDQ's lawyer said a shorter 16 to 26-week Order was appropriate and would allow IDQ to explore alternative treatment options.

IDQ had a long history of mental illness and experienced prominent residual symptoms despite receiving both oral and depot (injectable) medications. IDQ did not dispute that he experienced mental illness, but he didn't believe the medication was helping and he strongly objected to depot medication.

During the hearing, the Tribunal explored the possibility of the treating team supervising oral medication alone. The treating team was concerned that this would not be enough to maintain stability in IDQ's mental state. However, IDQ was to open to the suggestion.

The Tribunal accepted that IDQ required a reasonably lengthy Treatment Order, given his history and strong opposition to depot medication. However, the Tribunal also weighed up the positive signs in his recent progress – he was regularly attending appointments to receive his depot medication, he had changed his living circumstances, his views around seeking employment had subtly shifted and he was open to exploring medication supervision (which he had been closed to in the past). The Tribunal also accepted that IDQ was highly motivated by his desire to avoid going back to hospital and it placed weight on the fact he hadn't been back to hospital in over three years.

The Tribunal was mindful there was a risk of undermining IDQ's recent recovery progress by making another 52-week Order. The Tribunal acknowledged that it was not its role to direct the mode of treatment and that the decision of whether to pursue a trial of oral medication supervision remained at the discretion of the treating team in consultation with IDQ. However, based on the discussion at the hearing, the Tribunal felt IDQ's treatment was potentially at an important cross-road, so it made a 26-week Order.

In XOZ [2019] VMHT 15, the patient was experiencing a first episode psychosis. She hadn't received any psychiatric treatment prior to her admission however the treating team recommended a 52-week Community Treatment Order because she was in the early stages of recovery and it would give the treating team time to develop rapport and assist her to understand her illness.

However, the Tribunal decided a 17-week Order was appropriate because XOZ was experiencing a first episode psychosis. The Tribunal was satisfied this duration would give the treating team enough time to gauge XOZ's response to treatment and would give her access to a range of therapies during that time.

1.4 Working with our stakeholders

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 conducted our first survey of consumers, carers, family members and support people who attended a Tribunal hearing. This survey assessed the level of attendee 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 did 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 survey and the TAG is available in Part Three.

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 lived-experience workforce) are provided in Part Three.

Health services

The Tribunal's full and part time members each have responsibility for a number of health services for which they act as the liaison member and where they sit on hearings on a regular basis. 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 can 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 established by the Act. This includes providing local education sessions for all health services at least once and more commonly twice a year; and various papers and presentations delivered by the President, Deputy President and full and part time members.

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

Introduction of the *Medical Treatment Planning and Decisions Act 2016*

In March 2018 the *Medical Treatment Planning and Decisions Act 2016* (the MTPD Act) came into force. The MTPD Act allows medical treatment decision makers (decision makers) to make medical treatment decisions for people who are being treated on a voluntary basis and who lack capacity to consent to treatment.

The MTPD Act makes it clear that the persons preferences and values must be central to the decision maker's decision and the decision maker must make the decision they reasonably believe the person would have made if they had decision-making capacity. However, the MTPD Act does not apply if the person is a compulsory patient under the *Mental Health Act 2014* (the Act).

The Second Reading Speech for the *Medical Treatment Planning and Decisions Bill 2016* emphasises that the decision maker must respect the person's individuality and cannot make decisions based on how they would personally respond to disease or disability. Guidance materials prepared for mental health services state that it may be preferable to treat the person as a compulsory patient under the Act if the decision maker's consent to treatment will cause distress or negatively impact on their relationship with the person.

In LWX [2018] VMHT 33, the Tribunal examined the inter-relationship between the principles in the MTPD Act and the Act when it decided whether there was a less restrictive way to treat LWX. The case raised a complex issue about whether the authorised psychiatrist could rely on the consent of a guardian to override a person's objection to receiving psychiatric treatment.

LWX's guardians submitted that LWX did not need to receive compulsory treatment because they were willing and able to consent to her treatment in their capacity as her guardians. They were concerned about being left out of her care and formed the view that the Treatment Order was undermining their role as guardians.

The treating team was concerned about the practical difficulties of managing LWX as a voluntary patient, even with consent from her guardians. LWX was unpredictable and difficult to manage on the ward and at times had to be kept in a locked section of the ward which wasn't used for voluntary patients due to the restrictions it imposed on their freedom. LWX required other restrictive interventions during her hospital admission including short-acting intramuscular medications to manage outbursts of aggression. The treating team said that whilst LWX's mental state was improving, they thought it was necessary to make decisions about LWX's care 'there and then' without seeking approval from her guardians when issues arose.

In reaching its decision, the Tribunal had regard to the principles of the MTPD Act and the role of the decision makers, including that they respect the persons preferences and values and make a decision they believe the person would make, instead of the decision the decision maker would make for themselves.

The Tribunal decided that LWX could not be treated as a voluntary patient because her mental state had deteriorated since her previous admission and her behaviour had been difficult to manage and required a range of additional restrictive interventions. The Tribunal accepted the treating team's evidence that the unpredictable and volatile nature of LWX's presentation would make it difficult for her treating team to rely on consent from her guardians to provide her with the care she required.

In reaching this conclusion, the Tribunal acknowledged that LWX's guardians remained constructive in their supportive role and had not refused or undermined LWX's treatment in carrying out their duties as her guardians. However, the Tribunal decided it was more appropriate for LWX's psychiatric treatment to be regulated under the Act with a compulsory Treatment Order, rather than relying on the consent of LWX's guardians.

This approach was consistent with the underlying policy consideration of the MTPD Act that decision makers act in accordance with the wishes of the person. This also reflects the underlying policy consideration of the Act that people will not receive compulsory psychiatric treatment unless subject to a Treatment Order, whilst also ensuring people receiving compulsory treatment have access to various safeguards inherent in the making of a Treatment Order, including oversight by the Tribunal and the treating team has an obligation to consider the views of LWX and her guardians when making decisions about LWX's treatment.

Part 2
Hearing statistics for 2018–19

Key statistics at a glance * ^

	2018-19	2017-18	2016-17
Hearings listed **	**13,606**	13,563	12,760
Hearings conducted	**8,635**	8,279	7,817
Decision made	**7,751**	7,520	7,198
Adjourned	**884**	759	619
Treatment Orders made	**6,297**	6,127	5,925
TO / TTOs revoked	**497**	340	371
ECT Orders made	**592**	682	590
ECT applications refused	**98**	80	101
NMI hearings conducted	**1**	8	6
Statement of reasons requested	**243**	230	234
Applications to VCAT	**27**	39	33

Attendance at hearings[1]

	2018-19	2017-18	2016-17
Patients	**4,825**	4,753	4,709
Family members	**1,529**	1,464	1,313
Carers	**437**	547	422
Nominated persons	**249**	222	180
Medical treatment decision makers^^	**20**	8	–
Support persons^^	**8**	0	–
Interpreters	**363**	444	290
Legal representatives	**1,162**	1,213	1,198

* *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 2016-17 and 2017-18 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

^^ *Only in ECT hearings for voluntary adults.*

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.

1. Attendance of patients includes instances where the Tribunal visited the patient on the ward.

2.1 Treatment Orders

2.1.1 Outcomes of hearings regarding Treatment Orders

In 2018-19, the Tribunal made a total of 6,297 Treatment Orders (TOs) and revoked 497 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 (12) and 92 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*

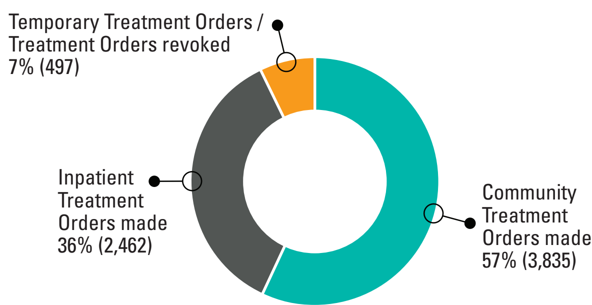


Table 1: *Determinations regarding Treatment Orders*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**3,835**	**57%**	3,547	55%	3,423	54%
Inpatient Treatment Orders made	**2,462**	**36%**	2,580	40%	2,502	40%
Temporary Treatment Orders / Treatment Orders revoked	**497**	**7%**	340	5%	371	6%
Total	**6,794**	**100%**	6,467	100%	6,296	100%

Figure 2: *Duration of Community Treatment Orders made*

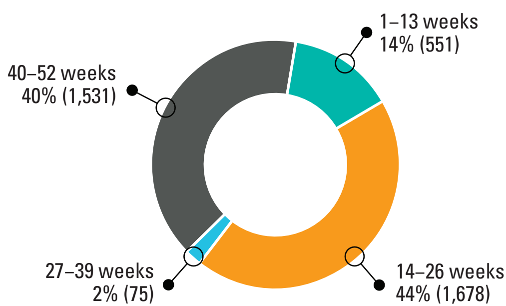


Table 2: *Duration of Community Treatment Orders made*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
1–13 weeks	**551**	**14%**	464	13%	464	13%
14–26 weeks	**1,678**	**44%**	1,471	41%	1,331	39%
27–39 weeks	**75**	**2%**	61	2%	61	2%
40–52 weeks	**1,531**	**40%**	1,551	44%	1,567	46%
Total	**3,835**	**100%**	3,547	100%	3,423	100%

Figure 3: *Duration of Inpatient Treatment Orders made*

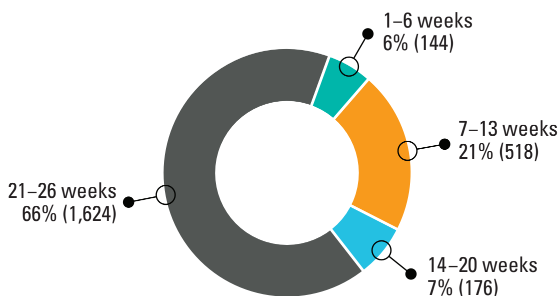


Table 3: *Duration of Inpatient Treatment Orders made*

	2018–19		2017-18		2016-17	
	No.	%	No.	%	No.	%
1–6 weeks	**144**	**6%**	200	8%	162	6%
7–13 weeks	**518**	**21%**	455	18%	490	20%
14–20 weeks	**176**	**7%**	158	6%	150	6%
21–26 weeks	**1,624**	**66%**	1,767	68%	1,700	68%
Total	**2,462**	**100%**	2,580	100%	2,502	100%

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. After conducting the hearing the Tribunal must either make a Treatment Order or revoke the Temporary Treatment Order.

Table 4: *Outcomes of 28 day hearings*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**1,352**	**42%**	1,316	42%	1,229	41%
Inpatient Treatment Orders made	**1,580**	**50%**	1,654	52%	1,607	53%
Temporary Treatment Orders revoked	**249**	**8%**	189	6%	186	6%
Total	**3,181**	**100%**	3,159	100%	3,022	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 reasons for revocation of a Temporary Treatment Order were as follows:

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

	2018–19	2017–18	2016–17
Treatment was able to be provided in a less restrictive manner	**69%**	77%	59%
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%**	7%	16%
Immediate treatment was not able to be provided	**15%**	12%	14%
The person did not have a mental illness	**9%**	4%	11%
Total	**100%**	100%	100%

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

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*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**2,247**	**81%**	2,002	82%	1,926	80%
Inpatient Treatment Orders made	**349**	**13%**	345	14%	362	15%
Treatment Orders revoked	**172**	**6%**	97	4%	113	5%
Total	**2,768**	**100%**	2,444	100%	2,401	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 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 **

	2018–19	2017–18	2016–17
Treatment was able to be provided in a less restrictive manner	**78%**	65%	62%
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	**8%**	18%	19%
Immediate treatment was not able to be provided	**11%**	12%	12%
The person did not have a mental illness	**3%**	5%	7%
Total	**100%**	100%	100%

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

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*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Community Treatment Orders made	**359**	**43%**	336	43%	376	45%
Inpatient Treatment Orders made	**376**	**46%**	384	50%	401	48%
Temporary Treatment Orders / Treatment Orders revoked	**88**	**11%**	53	7%	55	7%
Total	**823**	**100%**	773	100%	832	100%

The 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 **

	2018–19	2017–18	2016–17
Treatment was able to be provided in a less restrictive manner	**59%**	77%	46%
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	**19%**	13%	25%
Immediate treatment was not able to be provided	**10%**	5%	14%
The person did not have a mental illness	**12%**	5%	15%
Total	**100%**	100%	100%

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

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*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Community Treatment Orders made	105	16%	84	13%	103	16%
Inpatient Treatment Orders made	501	76%	539	82%	482	77%
Treatment Orders revoked	56	8%	36	5%	45	7%
Total	662	100%	659	100%	630	100%

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

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

	2018–19	2017–18	2016–17
Treatment was able to be provided in a less restrictive manner	**23%**	15%	9%
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%**	5%	4%
Immediate treatment was not able to be provided	**67%**	75%	87%
The person did not have a mental illness	**5%**	5%	0%
Total	**100%**	100%	100%

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

2.2 ECT Orders – Adults

2.2.1 Outcomes of applications for an ECT Order

In 2018-19 the Tribunal heard a total of 680 applications for an electroconvulsive treatment (ECT) Order. 539 ECT Orders were made for adult compulsory patients and 98 applications were refused. 43 ECT Orders were made in relation to adults being treated as voluntary patients.

Table 12: *Outcomes for applications of an ECT Order*

	2018–19	2017–18	2016–17
Compulsory adult patients			
ECT Orders made	**539**	672	588
ECT applications refused	**98**	79	100
Voluntary adult patients			
ECT Orders made	**43**	9	–
ECT applications refused	**0**	1	–
Total	**680**	761	688

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.

Figure 4: *Determinations regarding ECT applications*

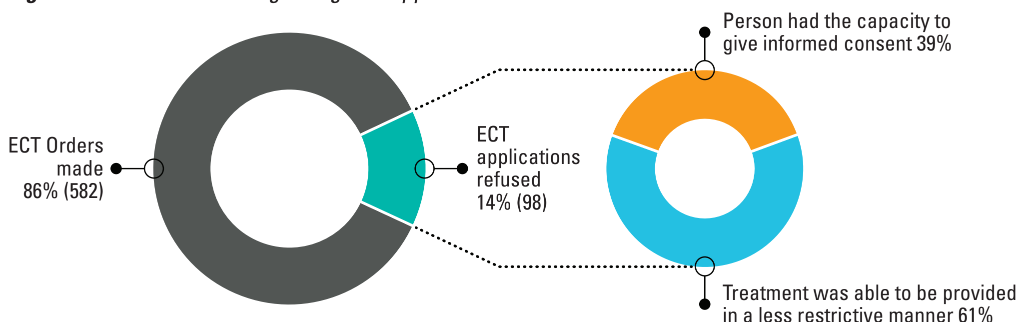


Table 13: *Determinations regarding ECT applications*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
ECT Orders made	**582**	**86%**	681	89%	588	85%
ECT applications refused	**98**	**14%**	80	11%	100	15%
Total	**680***	**100%**	761#	100%	688	100%

** One additional ECT application was determined as no jurisdiction.*
 # A further two ECT applications were determined as no jurisdiction and two ECT applications were struck out.

*Table 14: Reasons applications for an ECT Order were refused **

	2018–19	2017–18	2016–17
Treatment was able to be provided in a less restrictive manner	**61%**	65%	55%
Patient had the capacity to give informed consent	**39%**	34%	38%
Tribunal has insufficient information to make a decision	**–**	–	6%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	**0%**	1%	–
Total	**100%**	100%	100%

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

Figure 5: *Duration of ECT Orders*

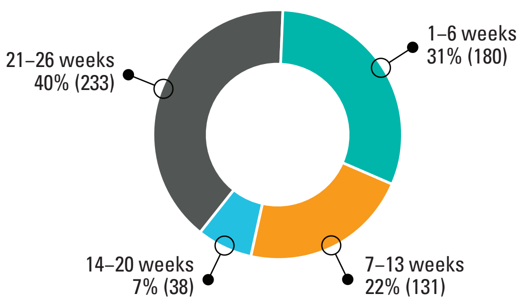


Table 15: *Duration of ECT Orders*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
1–6 weeks	**180**	**31%**	254	37%	308	52%
7–13 weeks	**131**	**22%**	192	28%	104	18%
14–20 weeks	**38**	**7%**	34	5%	29	5%
21–26 weeks	**233**	**40%**	201	30%	147	25%
Total	**582**	**100%**	681	100%	588	100%

Figure 6: *Number of ECT treatments authorised*

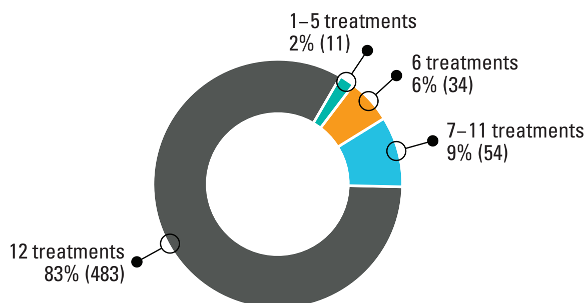


Table 16: *Number of ECT treatments authorised*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
1–5 treatments	**11**	**2%**	13	2%	13	2%
6 treatments	**34**	**6%**	40	6%	59	10%
7–11 treatments	**54**	**9%**	66	10%	122	21%
12 treatments	**483**	**83%**	562	82%	394	67%
Total	**582**	**100%**	681	100%	588	100%

2.2.2 Urgent ECT applications

The health service classifies ECT applications as either standard or urgent. Pursuant to s. 95(2) of the Act, urgent applications may only be made if the authorised psychiatrist is satisfied that the treatment is necessary as a matter of urgency to:

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

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

Table 17: *Proportion of applications for ECT Orders that were urgent*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Urgent applications for ECT	**360**	**53%**	439	58%	405	59%
Standard applications for ECT	**320**	**47%**	322	42%	283	41%
Total	**680**	**100%**	761	100%	688	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 2018-19, the Tribunal heard four urgent after-hours ECT applications. All four applications were granted.

2.2.3 Elapsed time from receipt of ECT applications to hearing

The Tribunal's registry has strict processing requirements to assist it to decide when to list ECT applications, including urgent applications. These processing requirements were revised following the recent Supreme Court decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. The judgment emphasised patients' rights and the objectives and principles in the Act that promote participation in decision making. In this context, the Tribunal's listing processes consider patient participation in hearings as well as the urgency of the application. Particular caution is taken in relation to listing hearings on the same day or the day after an application is received.

Urgent applications are still handled expeditiously but, based on advice from the TAG and our consideration of the Supreme Court decision, the Tribunal will, where appropriate, seek to allow more time for preparation and participation by consumers and carers.

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

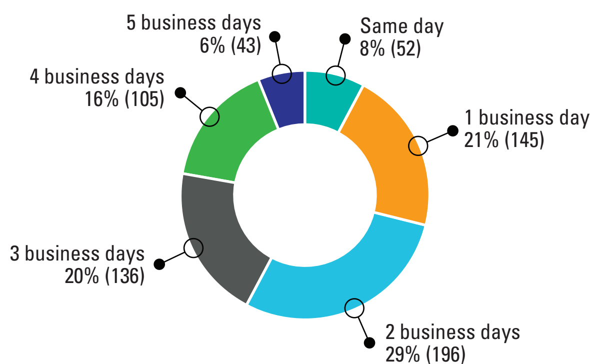


Table 18: *Elapsed time from receipt of ECT applications to hearing*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Same day	**52**	**8%**	104	14%	94	14%
1 business day	**145**	**21%**	216	28%	216	32%
2 business days	**196**	**29%**	179	24%	159	22%
3 business days	**136**	**20%**	124	16%	94	14%
4 business days	**105**	**16%**	84	11%	82	12%
5 business days	**43**	**6%**	50	7%	38	6%
Total	**677***	**100%**	757	100%	683	100%

** Three ECT hearings were conducted out of time because of Tribunal error.*

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

Compulsory patients

During 2018-19, three applications for an ECT Order were received relating to a compulsory patient under 18 years of age. All applications were granted.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2018-19, the Tribunal received seven applications for an ECT Order related to a young person being treated as a voluntary patient. All applications were granted.

Table 19: *Determinations regarding young person ECT applications*

	2018–19	2017–18	2016–17
Compulsory patients			
ECT Orders made			
Patient's age: 13	**0**	1	0
Patient's age: 14	**1**	0	0
Patient's age: 17	**2**	0	0
Voluntary patients			
ECT Orders made			
Patient's age: 14	**2**	0	0
Patient's age: 15	**2**	0	0
Patient's age: 17	**3**	0	2
Voluntary patients			
ECT applications refused			
Patient's age: 17	**0**	0	1
Total	**10**	1	3

2.4 Neurosurgery for mental illness

During 2018-19, the Tribunal received one application to perform neurosurgery for mental illness (NMI). The application was granted.

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

Application	1
Applicant mental health service	Neuropsychiatry Unit, Royal Melbourne Hospital
Diagnosis	Obsessive compulsive disorder
Proposed Treatment	Deep brain stimulation
Location of patient	VIC
Hearing outcome	Granted

2.5 Security patients

During 2018-19, the Tribunal made 86 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

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

	2018–19	2017–18	2016–17
Hearings for a security patient			
28 day review			
Remain a security patient	**75**	69	59
Discharge as a security patient	**1**	2	6
Six month review			
Remain a security patient	**5**	6	9
Discharge as a security patient	**0**	0	0
Application for revocation by or on behalf of the patient			
Remain a security patient	**5**	3	4
Applications struck out	**0**	3	0
Total	**86**	83	78
Application by a security patient regarding leave			
Applications granted	**0**	0	0
Applications refused	**0**	0	0
Total	**0**	0	0

2.6 Applications to review the transfer of patient to another service

During 2018-19, the Tribunal received eight applications to review the transfer of a patient to another health service.

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

	2018–19	2017–18	2016–17
Applications granted	**4**	1	0
Applications refused	**3**	4	5
Applications struck out	**0**	0	1
No jurisdiction	**1**	0	1
Total	**8**	5	7

2.7 Applications to transfer a patient interstate

During 2018-19 there were two applications received by the Tribunal to transfer a patient interstate. Both applications were granted.

Table 23: *Number and outcomes of applications to transfer a patient interstate*

	2018–19	2017–18	2016–17
Applications granted	**2**	0	1
Applications refused	**0**	1	0
Total	**2**	1	1

2.8 Applications to deny access to documents

During 2018-19, the Tribunal received 67 applications to deny access to documents.

Table 24: *Number and outcomes of applications to deny access to documents*

	2018–19	2017–18	2016–17
Applications granted	**55**	54	39
Applications refused	**9**	16	10
Applications struck out	**3**	1	0
No jurisdiction	**0**	1	0
Total	**67**	71	49

2.9 Applications for review by VCAT

During 2018-19, 27 applications were made to VCAT for a review of a Tribunal decision.

Table 25: *Applications to VCAT and their status*

	2018–19	2017–18	2016–17
Applications made	**27**	39	33
Applications withdrawn	**11**	18	14
Applications struck out	**0**	0	2
Applications dismissed	**0**	1	1
Hearings vacated	**3**	0	0
Decision set aside by consent	**0**	1	9
No jurisdiction	**2**	–	–
Applications proceeded to full hearing and determination	**10**	13	1
Applications pending at 30 June	**4**	6	6

Table 26: *Outcomes of applications determined by VCAT*

	2018–19	2017–18	2016–17
Decisions affirmed	**8**	13	6
Decisions varied	**1**	0	1
Decision set aside and another decision made in substitution	**0**	0	1
Orders revoked	**1**	0	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*

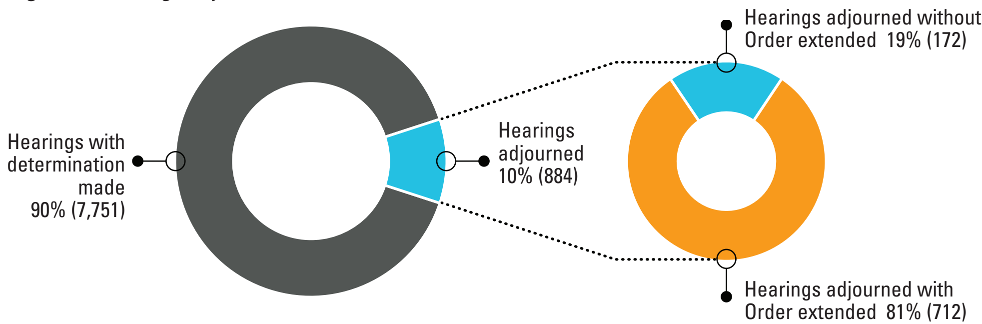


Table 27: *Hearings adjourned*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Hearings adjourned without Order extended	**172**	**19%**	179	24%	152	25%
Hearings adjourned with Order extended	**712**	**81%**	580	76%	467	75%
Total	**884**	**100%**	759	100%	619	100%
Hearings adjourned as a percentage of total hearings conducted	**10%**		9%		8%	

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

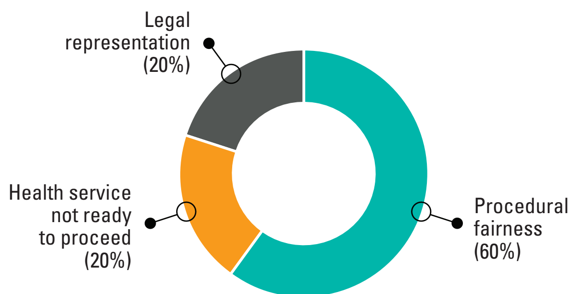


Table 28: *Reasons for adjournments with extension of Order*

	2018–19	2017–18	2016–17
Procedural fairness	**60%**	56%	57%
Health service not ready to proceed	**20%**	29%	23%
Legal representation	**20%**	15%	20%
Adjourn as application to deny access to documents refused	**0%**	< 1%	< 1%
Total	**100%**	100%	100%

2.11 Attendance and legal representation at hearings

Part Three of the Annual Report highlights the Tribunal's commitment to promoting the participation in hearings of patients and the people who support them. Pursuant to s.189 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 29: *Number and percentage of hearings with the patients and support people in attendance*

	2018–19		2017–18		2016–17	
	No.	%#	No.	%#	No.	%#
Patient	4,825	56%	4,753	57%	4,709	60%
Family member	1,529	18%	1,464	18%	1,313	17%
Carer	437	5%	547	7%	422	5%
Nominated person	249	3%	222	3%	180	2%
Medical treatment decision maker	20	<1%	8	<1 %	-	-
Support person	8	<1%	0	0%	-	-
Interpreter	363	4%	444	5%	290	4%
Legal representative	1,162	13%	1,213	15%	1,198	15%

 # Percentage of all hearings conducted in the financial year.

Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. The following table shows the number of patients who were legally represented at a hearing in 2018-19.

Table 30: *Legal representation at hearings*

	2018–19		2017–18		2016–17	
	No.	%#	No.	%#	No.	%#
Victoria Legal Aid	1,003	12%	1,065	13%	1,059	14%
Mental Health Legal Centre	123	1%	95	1%	80	1%
Private Lawyer	28	<1%	39	<1%	39	<1%
Other Community Legal Centre	8	<1%	14	<1%	20	<1%
Total legal representation	1,162	13%	1,213	15%	1,198	15%

 # Percentage of all hearings conducted in the financial year.

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 2018-19.

Table 31: *Primary diagnoses of patients who had Tribunal hearings*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
Schizophrenia	**4,122**	**48%**	3,884	47%	3,704	47%
Schizo-Affective disorder	**1,903**	**22%**	1,854	22%	1,628	21%
Bipolar disorder	**792**	**9%**	784	10%	781	10%
Depressive disorders	**296**	**3%**	362	4%	299	4%
Delusional disorder	**181**	**2%**	164	2%	153	2%
Dementia	**39**	**< 1%**	45	1%	54	1%
No diagnosis recorded	**401**	**5%**	278	3%	424	5%
Other organic disorders	**12**	**< 1%**	11	< 1%	14	< 1%
Eating disorders	**68**	**1%**	44	1%	44	1%
Other	**821**	**10%**	853	10%	716	9%
Total	**8,635**	**100%**	8,279	100%	7,817	100%

2.13 Mode of conducting hearings

As discussed in Part One, while the Tribunal prefers to conduct hearings in person, it is not always possible to do so. In 2018-19, less than one quarter of hearings were conducted via video conference.

Table 32: *Hearings conducted by mode*

	2018–19		2017–18		2016–17	
	No.	%	No.	%	No.	%
In-person	**6,629**	**77%**	6,268	76%	5,964	76%
Video conference	**1,976**	**23%**	2,006	24%	1,836	23%
Teleconference#	**33**	**0%**	11	0%	25	0%
Total hearings conducted#	**8,638**	**100%**	8,285	100%	7,825	100%

 # 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 adhere to. 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 2018-19, there were five 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 2018-19, 28 variation hearings were conducted more than 28 days after the variation of the Order. In two hearings, the cause was because of a Tribunal error. In three hearings, the cause was that the patient's treating team did not advise the Tribunal of the variation to the Treatment Order within time. In 23 of these hearings, 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, one ECT hearing was conducted out of time because of Tribunal error and one security patient hearing was adjourned beyond the 28 day time limit.

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 2018-19, 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 2018-19, we achieved this target 57% of the time.

Table 32: *Sending Treatment and ECT Orders #*

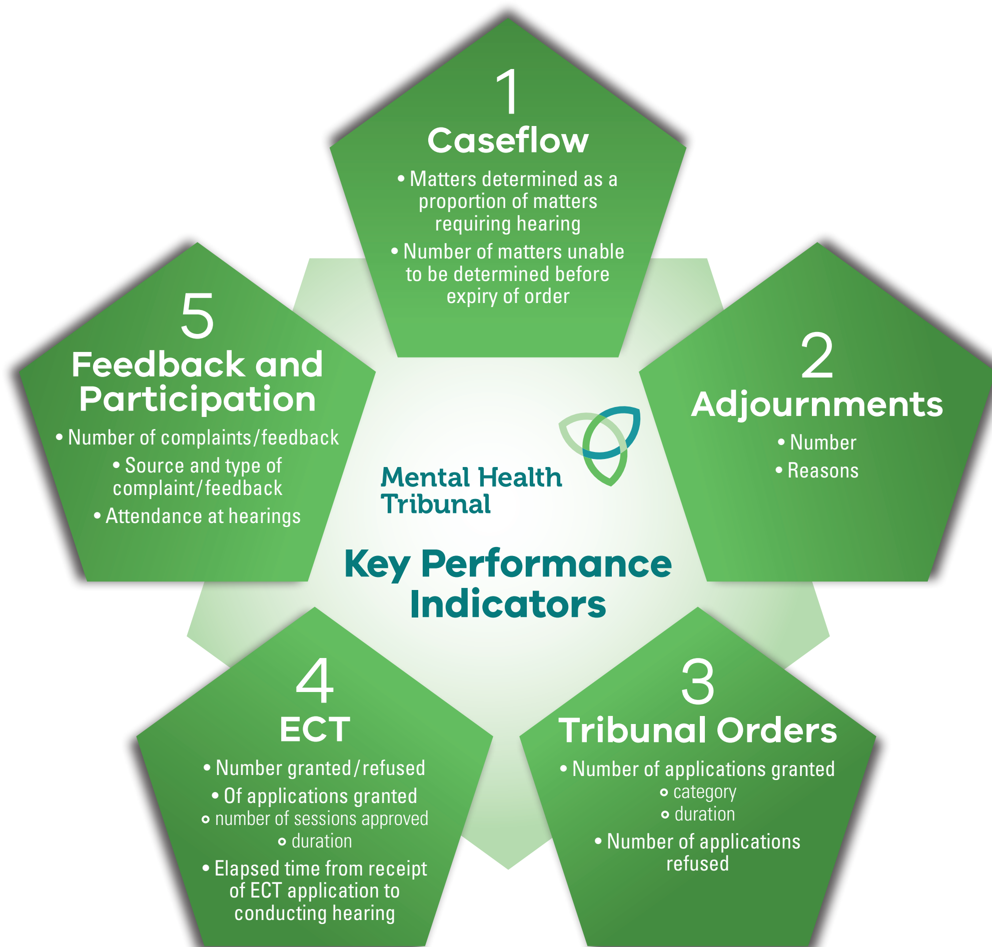
	2018–19	2017–18	2016–17
Percentage of Orders sent to parties within five working days of a hearing	57%	54%	59%
Average number of days to send Order to parties	6 days	6 days	6 days

 # The Tribunal's Registry aims to send Treatment and ECT Orders to relevant parties within five working days of a hearing

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*



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

'Consistently with the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, the objectives and principles [of the Mental Health Act] emphasise enabling and supporting decision-making, and participation in decision-making, by the person … including the exercise of the dignity of risk … There is emphasis on respecting the views and preferences of the person in relation to decisions about their assessment, treatment and recovery… Together with the operative provisions of the Mental Health Act, the objectives and principles are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.'

…

'Those giving practical effect to the requirement to take the patient's views and preferences into account (including VCAT and the MHT) must engage with those objectives and principles which emphasise patient participation and supported decision-making.'

(PBU & NJE v Mental Health Tribunal [2018] VSC 564, [67] and [256])

The Act sets down 12 mental health principles to guide the provision of mental health services. As the Victorian Supreme Court confirmed in its landmark decision in PBU & NJE v Mental Health Tribunal, persons performing duties or functions or exercising powers under the Act, including the Tribunal, must have regard to these principles. 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 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. Flowing from our vision, the strategic priorities set out in our Strategic Plan for 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 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.

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.

Mental Health Tribunal

Strategic Plan 2018–2020

Our Strategic Priorities

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.

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
- Survey participants' experience of Tribunal hearings to identify opportunities for improvement.

Our focus for 2019–2020:

- Develop new templates for hearing reports to improve patient experiences
- Collaborate with legal representatives to explore the role they can play in solution-focused hearings
- Conduct our second Tribunal Hearing Experience Survey including a survey of patients and carers who did not attend a hearing.

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
- Critically reflect on our own operation and contribute to analysis and review of the operation of the Act.

Our focus for 2019–2020:

- Ongoing engagement with the Royal Commission into Victoria's Mental Health System
- Trial new notice of hearing templates to increase attendance and participation at hearings
- Develop the Tribunal's first Reconciliation Action Plan.

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
- Develop a new website for the Tribunal to improve user experiences.

Our focus for 2019–2020:

- Explore options for a new case management system
- Transition to recording Tribunal decisions and case details electronically at hearings
- Improve the accessibility of our website through an accessibility audit.

Mental Health Tribunal

3.1 Consumers and carers: maximising opportunities for participation and engagement

Improving consumer and carer participation in hearings and engaging with consumers and carers to improve our resources and services remain high priorities 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.

3.1.1 Tribunal Advisory Group

The Tribunal Advisory Group (TAG) consists of consumers, carers, lived experience workforce members and senior Tribunal staff.

Front row: Margaret, Judith, Julie, Fiona, Ali
Back row: Pauline, Hannah, Jan, Matthew, Troy
Not pictured: Helen

During 2018-19, the TAG farewelled five long-standing members:

- Susan Lee, carer peer worker
- Helen Lococo, carer consultant
- Margaret Thorpe, carer member
- Matthew Scott, consumer consultant
- Hannah Daniels, consumer and carer

Susan took up a new role and Helen, Margaret, Matthew and Hannah each completed the maximum two terms as members. The Tribunal recognises and sincerely thanks all past and current TAG members for the invaluable support and expertise they bring to this important role.

The Tribunal will welcome four new TAG members in September 2019.

Throughout 2018-19, the TAG continued to provide strategic and operational advice to the Tribunal and co-produced key initiatives supporting the participation of consumers and carers. Two major TAG projects were completed by the Tribunal this year: the new Tribunal website and the Tribunal Hearing Experience (THE) Survey.

This year, the TAG has also been involved in:

- developing a new style guide for website and written communications
- conducting the 2019 Consumer and Carer Forum on 15 May, with the theme 'Have your say: Improving participation in hearings'
- reviewing the Tribunal's health service education strategy
- providing initial advice about the project to design a new template for hearing reports
- reviewing and advising on a new Chapter of the Tribunal's Guide to Solution-Focused Hearings on involving family, friends, carers and other support people in hearings
- developing two pamphlets about how to prepare for hearings – one general and one specifically about ECT hearings
- developing a new worksheet patients can use to plan what they want to say at Tribunal hearings.

3.1.2 Consumer and Carer Forum

This year, the TAG co-produced the agenda for the Consumer and Carer Forum including developing questions for the workshop. Of our Forum audience, the majority identified as consumers, carers, family or members of the lived experience workforce. The rest of our audience comprised a mix of mental health service staff, peak body staff, advocacy workers, legal representatives and Tribunal members and staff.

The three workshop questions were:

1. Why don't people attend Tribunal hearings?
2. What can the Tribunal do to help people attend hearings?
3. What do you need to be prepared for a hearing?

The wide range of insights and array of ideas uncovered in the workshop will inform the Tribunal's strategic and business planning to further improve consumer and carer participation and engagement in hearings.

Following the Forum, we asked people to complete an online evaluation survey. For all parts of the Forum, 80% of attendees agreed the forum was useful or very useful. In addition, over 85% of people agreed they learned something that would help them to support themselves or another person to participate in a Tribunal hearing.

3.2 Inaugural Tribunal Hearing Experience (THE) Survey

The Tribunal conducted its first Tribunal Hearing Experience Survey in October 2018. The survey was co-designed and tested with consumers and carers in late 2017. The survey is intended to inform the Tribunal about how consumers and carers experience Tribunal hearings and highlight areas where the Tribunal is doing well and where we can improve. The survey is part of our ongoing commitment to maximising consumer and carer participation in hearings, and a means by which consumers and carers play a central role in driving the Tribunal's continuous improvement agenda.

In 2018-19, the TAG co-designed the survey and all accompanying promotional materials. Advice from the TAG also informed the Tribunal's communications strategy with health services, peak bodies, lived experience workforce networks and other stakeholders.

Health services were sent copies of THE Survey fact sheet and forms, as well as posters to display. The website link to the survey was included on the poster and on the fact sheet for people who preferred to respond online. All surveys were anonymous.

THE Survey was physically posted to all consumers and the family members, carers and Nominated Persons who attended a hearing in October 2018. Of the 440 participants eligible to complete the survey we received 91 responses. The survey response rate was 21% and included both online and hard copy responses.

Dr Cheryl Reed of Health Community Consulting Group Pty Ltd analysed the survey results and made a number of recommendations, all of which have been accepted by the Tribunal.

Tribunal Hearing Experience Survey Findings

Overall, the Tribunal performed well on the measures canvassed in THE Survey:

Before the hearing:

- **82%** of respondents knew they could bring someone to support them at the hearing
- **78%** received a written notice about the hearing
- **65%** received a copy of 'Your Rights at a Hearing'
- **54%** felt they had enough time and information to prepare for the hearing.

During the hearing

- **90%** of respondents felt the Tribunal members explained what the hearing was about
- **82%** considered that the Tribunal members listened to their opinions
- **81%** felt the Tribunal members explained their decision in an understandable way
- **77%** considered that the Tribunal members treated them fairly throughout the hearing.

After the hearing

- **72%** received a copy of the determination
- **68%** of respondents were informed that consumers can appeal or request another hearing
- **65%** agreed with the outcome of the hearing
- **64%** received a copy of the Order or decision made by the Tribunal.

Recommendations:

1. The Tribunal should continue to work with mental health services to gain timely and accurate contact details for consumers and others attending hearings and continue to promote THE Survey during the fieldwork period at Tribunal venues and more broadly within the mental health service.
2. The Tribunal should develop a version of THE Survey for use with people who did not attend a hearing to identify ways the Tribunal may be able to increase attendance at hearings by consumers, carers, Nominated Persons and other family members.
3. The Tribunal should work with stakeholders to encourage the development of practices that improve the scheduling of hearings.
4. An updated version of THE Survey should separate the exploration of whether people have enough time and enough information to prepare for hearings.
5. The Tribunal should work with stakeholders to develop processes to support mental health service staff working with consumers, carers, family members and Nominated Persons, particularly in their preparation for hearings, to ensure the provision of consistent information.

The full report is available on the Tribunal's website: http://www.mht.vic.gov.au/news/findings-tribunals-hearing-experience-survey.

3.3 New website and information about the Tribunal designed with consumers and carers

On 15 May 2019 the Tribunal launched its new website at the Consumer and Carer Forum.

Our new website was designed to make it easier for consumers to understand what happens at the Tribunal, prepare for hearings and to know how to exercise their rights if they disagree with a decision of the Tribunal.

Consumers and carers were heavily involved in designing the new website. The TAG defined the key performance indicators describing what consumers should experience from a new website. Interviews were conducted with consumers and carers to understand why they visit the site and their needs and preferences. Insights gained from this consultation were then applied to the design of the new site. A prototype of the site was tested, refined and proven to be user-friendly by consumers and carers. The Tribunal produced videos for the website summarising the information consumers and carers look for. We also 'reconciled' the information on the website about hearings with our written information products, ensuring the content was the same.

The new website supports the realisation of key mental health principles by helping consumers and carers to inform themselves about Tribunal hearings and to make or be involved in decisions about treatment and recovery. In prioritising the needs and wishes of consumers and explaining how they can exercise their rights, the website also promotes their rights, dignity and autonomy.

Much of the key consumer and carer content on our website has been translated into other languages, and more translations will be added to the website during 2019-20.

3.4 Solution-focused hearings

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. 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.

The Tribunal is committed to facilitating and conducting solution-focused hearings and has been further developing our Guide to Solution-Focused Hearings in the Mental Health Tribunal (the Guide) and related resources.

3.4.1 New information and guidance

New chapter on involving family, friends, carers and other support people in hearings

In last year's Annual Report, we reported we were exploring ways to improve the participation of family and carers in hearings. This year, we released a new chapter to the Guide on involving family, friends, carers and other support people in hearings.

The chapter highlights the Tribunal's 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.

The purpose of the chapter is to provide a coherent framework and practical strategies for encouraging and facilitating the participation of support people in hearings. It is primarily intended to guide Tribunal members and mental health services, and outlines techniques to overcome common obstacles to participation.

As well as drawing on solution-focused hearings principles and the experience of Tribunal members, the chapter employs principles from the Client-centred Framework for Involving Families, particularly Single Session Family Consultations (SSFCs) developed by the Bouverie Centre, Victoria's Family Institute. The Tribunal acknowledges the contribution to the chapter of Dr Peter McKenzie, Carer Academic, Family Practice Consultant and Clinical Family Therapist at the Bouverie Centre, particularly in relation to how mental health services can prepare consumers and their support people for Tribunal hearings and useful strategies based on SSFC techniques more generally.

In preparing the chapter, the Tribunal consulted with a range of organisations and individuals and received feedback from the TAG, the Office of the Chief Psychiatrist, VMIAC, Tandem, Victoria Legal Aid, Tribunal members and carer consultants or advisors from mental health services.

The new chapter is available on the Tribunal's website.

SOLUTION-FOCUSED CASE STUDY

Involving support people in hearings

'Craig' is in his early twenties and lives with his parents. He had initially been placed on an Inpatient Temporary Treatment Order that had been varied to a Community Temporary Treatment Order six days before the Tribunal hearing. Craig was diagnosed with first episode psychosis following his return from interstate earlier this year. The previous six to nine months were characterised by Craig's behaviour becoming increasingly erratic and out of character (including alcohol and substance abuse, travelling, risk-taking behaviours and sleeping rough).

Craig and his parents attended the hearing. The Tribunal was advised that Craig did not want his parents to participate in the hearing and that Craig's parents had a letter they wanted to give to the Tribunal.

Initially, the Tribunal's legal member spoke with Craig and his parents outside the hearing room. They were all encouraged to come into the hearing room to discuss hearing arrangements and their preferences. After introductions, the Tribunal explained the legal framework and process. The Tribunal asked Craig's parents about the letter they had for the Tribunal and whether Craig had seen it – he had not. The Tribunal explained that if it was to have that information, fairness required that Craig should be aware of it too. Craig's parents agreed to this; however, the Tribunal suggested that they keep the letter for the time being while all participants considered how the hearing could best proceed.

Following its explanation about the hearing and Tribunal processes and the importance of taking into account all perspectives before making its decision, the Tribunal asked Craig whether he was prepared to have his parents remain in the hearing so that they could tell the Tribunal what they wanted it to know. He agreed. The Tribunal asked Craig's parents to keep their letter (which neither the Tribunal nor Craig had read) and simply talk to the Tribunal to the extent that they felt comfortable.

Craig provided his evidence clearly and thoughtfully and listened calmly as both his parents made brief comments, including some things that they knew Craig disagreed with. After considering all of the information before it, which had been heard by everyone involved, the Tribunal made a CTO for six months.

New appendix on risk as a consideration in decision-making under the Mental Health Act

We have also completed a new appendix to the Guide on the place of risk in decision-making under the Act. This appendix reflects on how what is sometimes referred to as the 'risk' criterion is being interpreted in practice. The criterion is section 5(b), one of the legal criteria for Treatment Orders, which requires the authorised psychiatrist and the Tribunal to be satisfied that, because a person has mental illness, they need immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or another person.

It is not uncommon for treating teams to seek a Treatment Order to manage the risk of a person's possible future serious deterioration so that they can act assertively if the need arises. The rationale seems to be that if a person is not on a Treatment Order, intervention will not be possible until a relapse fully plays out and the serious deterioration has become an actuality. However, as discussed in the new appendix to the Guide, this approach fails to recognise the preventative focus of the Act; essentially, it positions compulsory interventions as a post-crisis response rather than crisis-prevention tool, which arguably also leads to a paradoxical approach to the interpretation and application of the dignity of risk principle.

3.4.2 Review of the Report on Compulsory Treatment

The Tribunal is carrying out a project to update the template for the Report on Compulsory Treatment, which mental health services must prepare and give to the Tribunal and the consumer before Treatment Order hearings. The update is intended to create a clearer and more concise report template that incorporates the mental health principles of supported decision making and participation by consumers in decisions about their assessment, treatment and recovery. In particular, it is intended to help consumers to prepare and participate in hearings and to preserve and improve the therapeutic relationship between consumers and their treating teams.

Consultation has taken place with the TAG, clinicians, legal representatives and Tribunal members, in addition to the Tribunal's experience of listening to the views of patients about reports during hearings.

The outcome of the project should result in a report structure that is more collaborative, supports the patient in making and participating in decisions, is recovery-oriented and is the foundation for a solution-focused hearing. It is also intended to make reports shorter and easier to complete.

3.5 Transparency and understanding – an alternate approach to statements of reasons

This year, the Tribunal has developed an alternative statement of reasons template that members can use in appropriate cases. The template employs a more personalised style (such as using the consumer's own name or referring to them directly rather than by initials) and is most commonly used in cases where a consumer has requested a statement of reasons. It also simplifies the explanations of both the reasons for the hearing and what the Tribunal needs to consider.

More transparent, easy-to-read statements of reasons written to and for – rather than about – consumers allow them to better understand and reflect on their hearings and, in matters where the Tribunal made an Order, help them to prepare for any future hearings. Statements of reasons can highlight other medical issues and individual needs (including recovery goals) and record why the Tribunal thought an Order shouldn't be made or, alternatively, capture what was discussed in the hearing regarding the pathway towards voluntary treatment.

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

The following extracts illustrate the difference between the standard and alternative statements of reasons for a hypothetical patient, Patricia (or ABC) who has had a hearing for two reasons: because her Temporary Treatment Order was about to expire and she had also applied for it to be revoked.

The Tribunal publishes de-identified statements of reasons in this new style on AustLII.

Excerpt from standard statement of reasons template for Treatment Order hearings

1. Background

ABC's Order at time of the hearing:	Community Temporary Treatment Order expiring on 30 June 2019.
Treating mental health service:	XYZ Community Mental Health Clinic
Reasons for hearing:	ABC was on a Community Temporary Treatment Order. The Tribunal must have a hearing before this Order ends to decide whether she must continue to receive compulsory treatment. On 10 June 2019, ABC also applied to the Tribunal to revoke her Community Temporary Treatment Order.

2. The Issues

The Tribunal had to decide if ABC should be on a Treatment Order.

A Treatment Order means ABC's treating psychiatrist will make treatment decisions if ABC is unable to consent or refuses treatment and ABC's treating psychiatrist thinks there is no less restrictive way for ABC to be treated.

When making decisions, ABC's treating psychiatrist must have reasonable regard to ABC's views and preferences and will also talk to ABC's nominated person, guardian, or carer (if they have one) about ABC's treatment.

To decide if ABC should be on a Treatment Order, the Tribunal had to consider if the treatment criteria applied to ABC. The treatment criteria are listed in the *Mental Health Act 2014* ('the Act') and are attached at the end of this document.

When making a Treatment Order, the Tribunal must take into account the patient's views and preferences, and the views of their nominated person, guardian or carer.

The Tribunal must also take into account the *Charter of Human Rights and Responsibilities Act 2006* ('the Charter') when making its decision.

Excerpt from alternative statement of reasons template for Treatment Order hearings

1. Reason for the hearing

Patricia, when the Tribunal held this hearing you were on a Community Temporary Treatment Order ('CTTO') that was due to end on 30 June 2019. You had also applied to the Tribunal to have your CTTO revoked.

The Tribunal held the hearing so it could decide whether to:

- revoke your CTTO which would mean you would be a voluntary patient making your own decisions about treatment; or
- make another Treatment Order so you would continue to be a compulsory patient. If a person is a compulsory patient their views about treatment still need to be considered, but their treating psychiatrist will make treatment decisions if the person is unable to consent or refuses treatment, and there is no less restrictive way for them to be treated.

To make this decision the Tribunal had to consider whether the treatment criteria applied to you. The treatment criteria are listed in the *Mental Health Act 2014* ('the Act') and are attached at the end of this document. The Tribunal also had to take into account your rights under the *Charter of Human Rights and Responsibilities Act 2006* ('the Charter').

3.6 ECT guidelines

This year, the Tribunal completed a set of guidelines for ECT hearings and Orders to assist Tribunal users in relation to key issues that arise in practice. In particular, the guidelines highlight key principles from the Supreme Court's landmark decision in *PBU & NJE v Mental Health Tribunal*, which clarified how the ECT provisions of the Act should be interpreted and applied.

Among other things, the guidelines outline the Tribunal's comprehensive registry procedures that are used to list ECT applications. These procedures were revised following the Supreme Court's decision in order to strike a better balance between patients' rights and the objectives and principles in the Act, alongside considerations of clinical urgency. In all cases, the Tribunal's registry seeks to maximise the notice period to allow as much time as practicable for the patient, and any support person or legal representative, to prepare for and attend the hearing.

The guidelines also highlight key principles in the Supreme Court's decision relating to the criteria that apply to applications for and decisions regarding ECT Orders. Various aspects of the decision summarised in the guidelines emphasise the importance of considering the mental health principles. For example, the guidelines confirm that a functional test of capacity applies which focuses on the process of making a decision rather than the content of the decision made. This promotes the dignity of risk principle by confirming that a person does not lack capacity to give informed consent simply by making a decision others consider to be unwise according to their individual values and situation.

Drawing on the Supreme Court's decision, the guidelines also confirm that the requirement to consider whether there is no less restrictive way for the person to be treated is to ensure that treatment is provided in a manner that respects human rights. The guidelines clarify for Tribunal users that the 'no less restrictive test' is intended to promote participation and supported decision making and, where possible, to incorporate recovery as an important therapeutic objective in a holistic consideration of the person's health.

3.7 The Tribunal's engagement with the Royal Commission into Victoria's Mental Health System

In its formal submission to the Royal Commission, the Tribunal used the principles of the Mental Health Act to distil themes and systemic issues illustrated by what we learn about in hearings regarding people's engagement with clinical mental health services as a consumer, carer, family member or support person. While the Mental Health Act is focused on compulsory treatment, the principles have a broader relevance and they provide a sound starting point for articulating the characteristics of an effective mental health system focused on meeting the needs of consumers and carers.

The Tribunal emphasised that it often observes effective and collaborative engagement between consumers, carers and service providers, but resource and capacity pressures mean that often this isn't the case. The Tribunal provided a detailed examination of what it regards as the key shortfalls of the current system and argued strongly for a focus on rebuilding an appropriate culture of service delivery.

The Tribunal's submission to the Royal Commission is available on our website, and we look forward to ongoing engagement with the process of the Royal Commission.

3.8 Reconciliation Action Plan

One of the mental health principles is that Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to. During the year, the Tribunal formed a Working Group to develop a Reconciliation Action Plan (RAP) to help us to reflect on the implications of this principle in our operation. A RAP is a tool designed by Reconciliation Australia that assists organisations to develop initiatives and take action that will contribute to reconciliation.[2]

The Tribunal will submit its Reflect RAP to Reconciliation Australia in 2019 for endorsement. This work will form the foundation for future RAPs.

2. Reconciliation Australia, 29 May 2019, <https://www.reconciliation.org.au/reconciliation-action-plans/>

3.9 Tribunal project: duration of Orders

The Tribunal's research working group (RWG) continued its project to understand the extent to which the Tribunal determines the duration of Treatment Orders made under the Act. The preliminary findings from initial qualitative assessment measures carried out last year were included in the 2017-18 Annual Report.

In summary, analysis of collected data revealed that the Tribunal sets a different duration than requested by the authorised psychiatrist in 20% of hearings where a Treatment Order is made. Of these hearings, the majority of factors that influenced the Tribunal's decision were based on ensuring congruence with the principles of the Act (a relevant factor in 78% of hearings) and the evidence provided by one or more of the participants at the hearing (a relevant factor in 73% of hearings). See Figures 12 and 13.

Further correlational analysis revealed that these two factors were present together in a majority of hearings (60%) (Table 33). The results of the correlational analysis suggest that the information provided by participants in a hearing is important and directly relevant to the Tribunal's consideration of the principles and objectives of the Act, and consequently influences the Tribunal when it is exercising its discretion to set the duration of Treatment Orders. In the majority of cases where the Tribunal sets a duration different to that requested by the treating team, it sets a shorter duration (92%) (Figure 12).

The analysis also revealed that in cases where the Tribunal made a shorter duration, there were higher levels of attendance from the patient, their support person or their legal representative when the Tribunal considered information provided by the participants and congruence with the principles of the Act as factors of their decision. This suggests that participation by consumers and their support people will help provide the Tribunal with the information it needs to meaningfully consider the Act's principles and objectives when exercising its discretion to determine the duration of Treatment Orders (Table 34).

The Tribunal hopes to publish detailed findings next year.

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

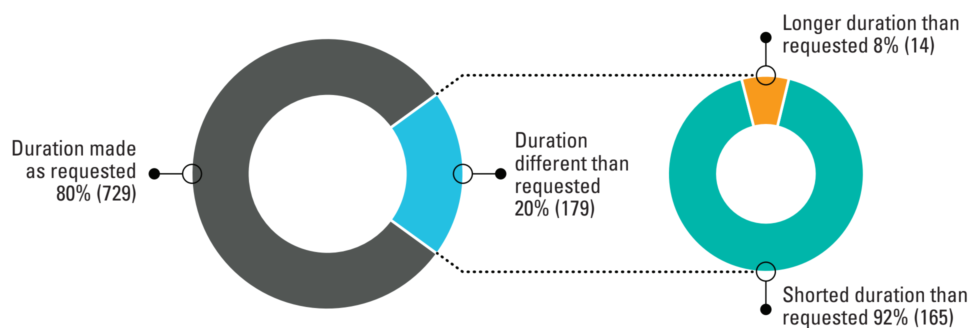


***Figure 13:** Factors in deciding different Treatment Order duration for hearings*

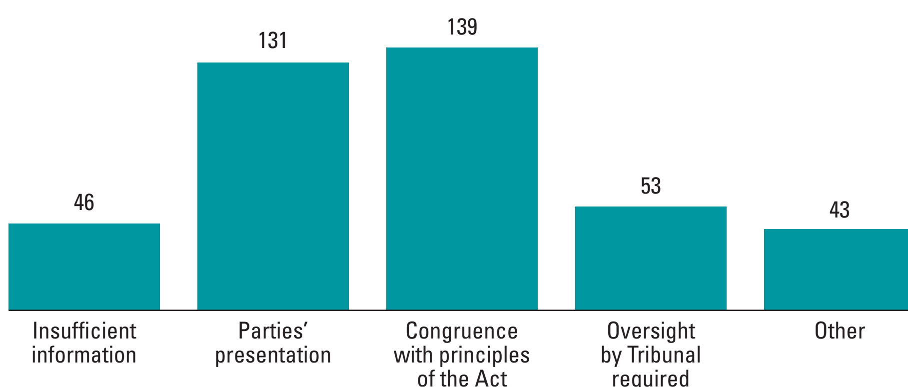


***Table 33:** Factors also present when parties' presentation was a factor when setting duration*

	Number	% of total hearings with different duration*
Number of Orders made with different duration than requested	179	
Parties' Presentation	131	73%
+ Congruence with principles of the Act	108	60%
+ Oversight by Tribunal required (to enable further review)	32	18%
+ Insufficient information for care and risk assessment	29	16%
+ Other	25	14%
+ No other factor reported	11	6%

***Table 34:** Correlation between factors and attendance when Treatment Order made with shorter duration*

	Parties' presentation	Congruence with principles	Insufficient information	Oversight by Tribunal required	Other
Number of times factor present	120	134	43	53	37
Patient	103 (86%)	108 (81%)	25 (58%)	35 (66%)	29
Legal representative	40 (33%)	42 (31%)	12 (28%)	11 (20%)	8
Support person	47 (39%)	50 (37%)	6 (14%)	13 (25%)	11

** Sum of percentages does not equal 100% because the data collection allowed for more than one factor to be present in each case.*

Appendices

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.

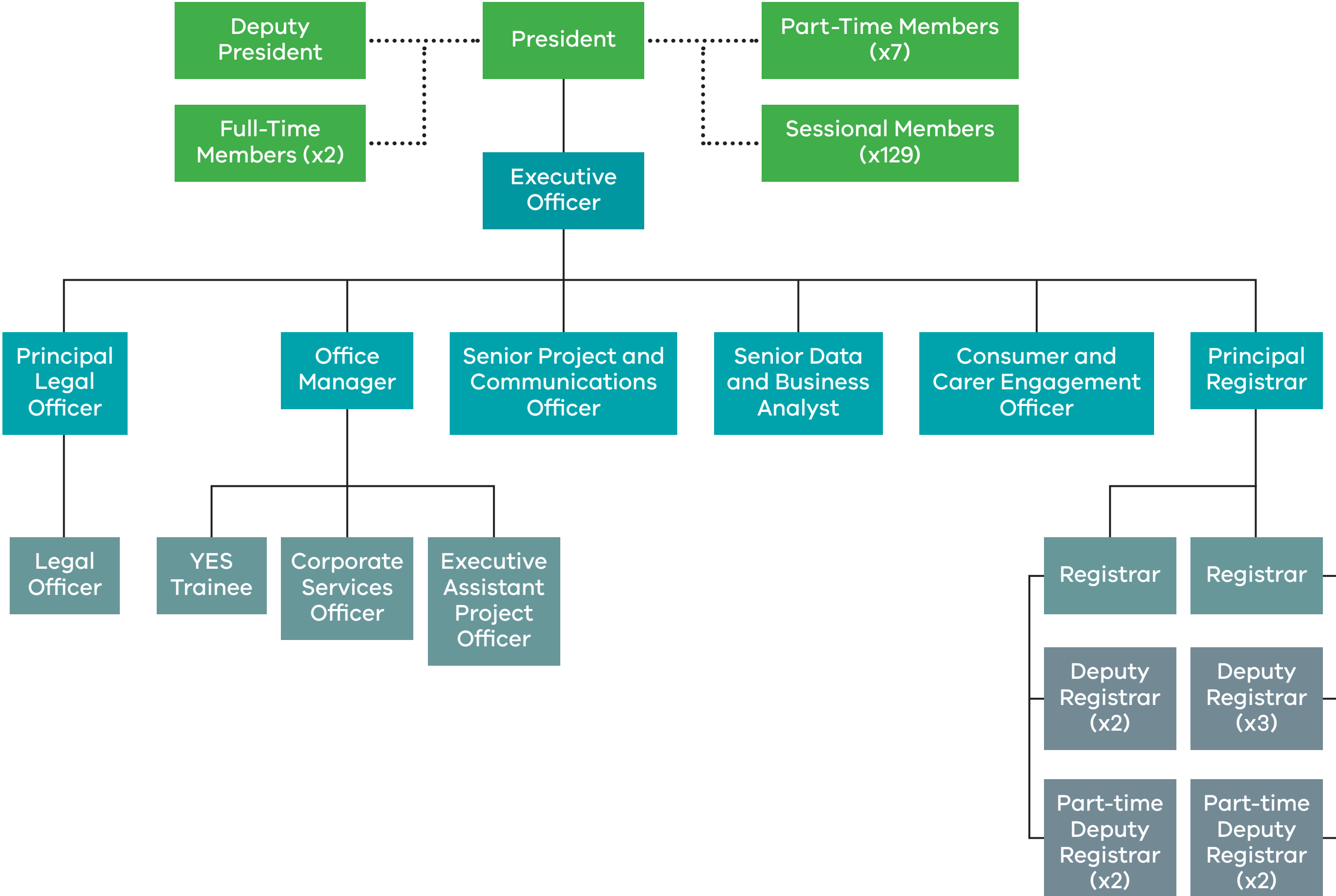
Appropriation

	2018-19	2017-18	2016-17	2015-16
TOTAL	**$9,877,592**	$9,640,663	$8,249,445	$8,109,551

Expenditure

Full and part-time member salaries	**$1,693,225**	$1,559,784	$1,308,120	$1,343,608
Sessional member salaries	**$4,315,542**	$4,413,473	$3,792,832	$3,260,481
Staff Salaries (includes contractors)	**$1,821,447**	$1,624,924	$1,576,658	$1,875,774
Total Salaries	**$7,830,214**	$7,598,191	$6,677,610	$6,479,866
Salary On costs	**$1,256,896**	$1,217,943	$1,090,767	$1,078,171
Operating Expenses	**$712,722**	$653,266	$486,944	$548,733
TOTAL	**$9,799,832**	$9,469,400	$8,255,321	$8,106,767
Balance	**$77,760**	$171,263	-$5,876	$2,784

Appendix B
Organisational Chart as at 30 June 2019



Appendix C
Membership List as at 30 June 2019

The composition of the Tribunal includes 81 Female and 59 Male members, made up of four full time members (the President, Deputy President and two Senior Legal Members), seven part time members and 129 sessional members across all categories (legal, psychiatrist, registered medical practitioner and community).

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	Period of Appointment
Legal Members	
Mr Brook Hely	25 Feb 2011 - 24 Feb 2021
Ms Kim Magnussen	25 Feb 2011 - 24 Feb 2021
Psychiatrist Member	
Dr Sue Carey	25 Feb 2011 - 24 Feb 2021
Community Members	
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 *(Retired 30 April 2019)*
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 *(Retired 30 June 2019)*
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 *(Retired 30 June 2019)*
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

Sessional Members	Period of Appointment
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 2018-19, 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 14 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. Three of the requests were withdrawn or were not proceeded with, no documents were found in relation to one request and three requests were handled as formal FOI requests.

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.ovic.vic.gov.au.

Part II information statement

Part II of the FOI Act requires agencies to publish lists of documents and information relating to types of documents held by the agency, the agency's functions and how a person can access the information they require. The purpose of Part II of the FOI Act is to assist the public to exercise their right to obtain access to information held by agencies. Part II Information Statements provide information about the agency's functions, how it acts, the types of information the agency holds and how to access that information. The Tribunal has published its Part II Information Statement on its website.

Application and operation of the *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 2018-19 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

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