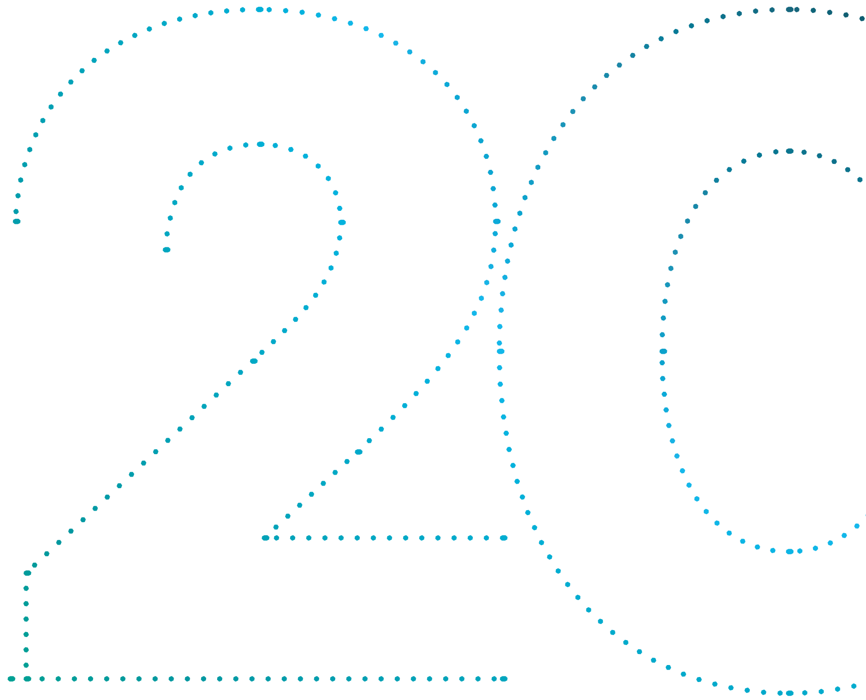
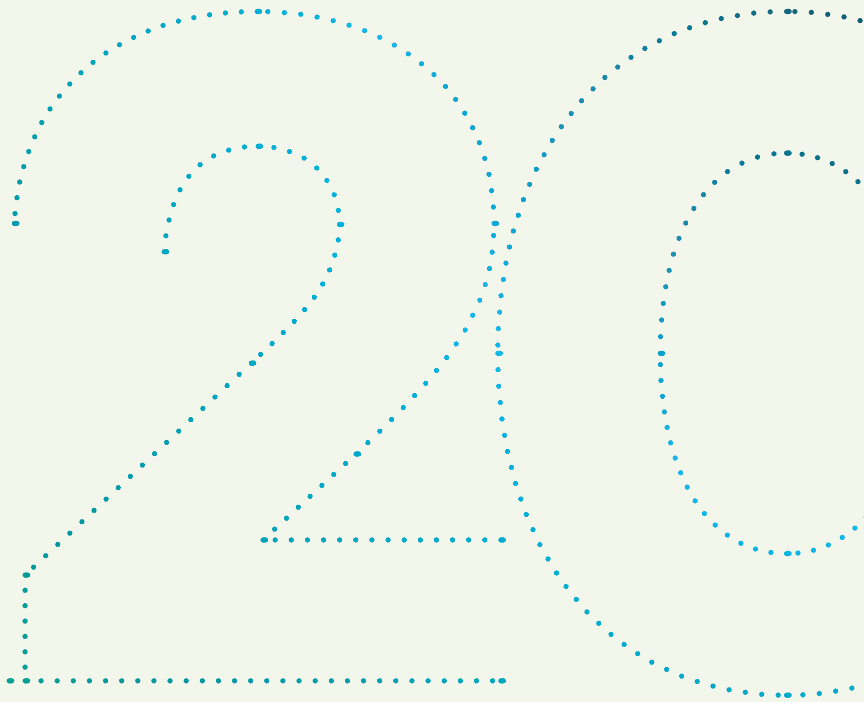


Mental Health Tribunal
2019-2020 Annual Report

Mental Health
Tribunal



Mental Health Tribunal
2019-2020 Annual Report

Protecting the rights and dignity of people with mental illness

Mental Health Tribunal

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20 August 2020

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 2019 to 30 June 2020.

Yours sincerely

Matthew Carroll
President

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President's Message

The year covered by this annual report is, of course, unlike any other. The Tribunal has always operated with a deliberate focus on bringing consumers, carers, treating teams and Tribunal members together, to discuss and explore the issues relevant to a hearing in person. Accordingly, the restrictions that were essential to protect public health in the pandemic meant that like so many organisations across Victoria and around the nation, the Tribunal had to grapple with the existential challenge of needing to urgently redesign almost every aspect of our long-standing operating systems. Our business continuity and disaster management plan didn't have a complete answer, because it assumed that even a disaster would be somewhat contained in place and time, whereas the COVID-19 pandemic has engulfed everyone for many months – and, at the time of preparing this annual report (early in the period of stage four restrictions), it continues to disrupt our daily lives in previously unimaginable ways.

On 23 March, when the Tribunal suspended all in-person hearings at mental health services, the effects of the COVID-19 pandemic slashed the Tribunal's capacity to conduct hearings by 60%. The Tribunal knew that at the same time our capacity was reduced, individuals would continue to be placed on and treated under compulsory Orders. Those people had rights guaranteed under the Mental Health Act and the Charter of Human Rights and Responsibilities that the Tribunal is charged to protect. Also, for some people in acute, even life-threatening situations, who were unable to consent and for whom electroconvulsive treatment was the least restrictive form of treatment available, that treatment could only be provided if the Tribunal conducted a hearing to determine whether to make an Order. We found ourselves having to prioritise some hearings over others, while trying to manage our limited capacity across all the hearings that needed to be conducted. Knowing the difficult and stressful situations facing many consumers and carers made defining priorities an especially challenging and often troubling task for the Tribunal.

Initially, we expected it would take up to three months to design and implement the infrastructure needed to restore our hearing capacity. What was needed was far more complex than simply doing over the telephone or by video everything that had previously been done face-to-face. Our systems for distributing information prior to hearings, and recording and finalising hearing outcomes, were entirely paper-based; they needed to become electronic. Arrangements that catered for hearing participants who were co-located or located at no more than two separate locations needed to extend to accommodate participants spread across several locations. Remote access to enable staff to work from home had to be developed and enabled. Members and staff needed training across a plethora of new systems.

Work on this extraordinary and unexpected reform agenda remains ongoing and, until it is completed, our capacity will not be as stable as we would like and may still at times be less than the demand for hearings. However, I am pleased to report that the Tribunal was able to re-establish sufficient capacity to conduct all required hearings within five weeks. Despite initial concerns that we would be unable to conduct (or miss) up to 100 hearings each week, for the five-week period when our capacity was insufficient to meet demand, a variety of strategies meant we only missed a total of 108 matters. I use the word 'only' very cautiously - I acknowledge the impact was very significant for the individuals affected by those missed hearings and I repeat the apology offered by the Tribunal at that time.

This exceptionally rapid and effective response to the COVID-19 pandemic was a result of many factors. The efforts of Tribunal staff have been remarkable. Their workdays have involved an unrelenting pattern of having to first understand the latest problems or challenges, then design solutions and immediately implement those solutions while, at the same time, keeping everything running. Similarly, Tribunal members have had to rethink how they approach their roles and maintain their focus while also undertaking training in new IT systems (stressful even in the best of times). Their attitude has constantly been 'just show me what I need to do'. To staff and members, I cannot thank you enough for your hard work and commitment during these very difficult times.

I also acknowledge the cooperation the Tribunal received from health services across Victoria. The need to redesign our processes and listing practices profoundly changed the way in which health services interact with the Tribunal on a daily basis. Their flexibility and engagement in the context of a fast-moving crisis that did not allow time for genuine consultation is greatly appreciated. Similar impacts were experienced by the providers of legal representation services – Victoria Legal Aid and the Mental Health Legal Centre – both of whom adapted their approach to fit within the Tribunal's new practices. Critical support was provided by the Entity Relationships Unit and Mental Health and Drugs Branch in the Department of Health and Human Services. The 'back of house' changes needed to implement these reforms would have been impossible without their constant assistance.

A most important thank-you is owed to consumers and carers for their goodwill and engagement. Consumers and carers were always understanding of the need for us to do things very differently, and sometimes not as seamlessly as we would hope. Pleasingly, and unexpectedly, the rate of consumer attendance at hearings has risen in the period affected by the pandemic. We are monitoring this closely and reflecting on its potential implications for how we facilitate hearings in the future, even after the pandemic has abated. It's not an exaggeration to say we yearn to once again be able to meet directly with the people participating in hearings as it is this type of engagement that provides the greatest opportunity to conduct the most effective hearings. However, if meeting in person discourages some people from participating, providing alternative modes of participation is a modification we need to consider.

It is important to remember that 2019-20 was not defined exclusively by COVID-19. Prior to and even during the pandemic, the Tribunal has continued to contribute to a number of critical processes concerning mental health and pursue a range of improvement initiatives. Details are provided in the body of this report, including in relation to:

- the Tribunal's ongoing engagement with the Royal Commission into the Victorian Mental Health System, and our submission to the federal Productivity Commission's Mental Health Inquiry
- a re-design of the template used for hearing reports to make them recovery-focused, better for consumers to read, easier for clinicians to prepare and a foundation for a solution-focused hearing
- expanding the suite of online information to include resources for families and carers
- the progressive re-design of hearing notices and templates for hearing determinations and Orders so they are more accessible and easily understood by consumers and carers
- the second Tribunal Hearing Experience Survey, which this year was extended to include consumers and carers who decided not to attend hearings
- the development of a comprehensive education strategy.

These initiatives were taken in partnership with the Tribunal Advisory Group (TAG), which once again played a critical role in defining an ambitious and outwardly focused work agenda for the Tribunal. To the members of the TAG, especially those who completed their terms this year, I thank you for your advice and input: it has been invaluable and greatly appreciated.

Everyone will be cautious about being too definitive regarding what the year ahead holds. Initially, we will concentrate on completing the re-design of our processes in response to the pandemic, with a particular focus on consulting with stakeholders to understand how the changes have impacted them and identify adjustments that might be required. This is necessary not only because it appears our new processes will be needed for some time yet, but also because some of the changes (in particular paperless processes) represent significant improvements on the past and will become permanent.

More broadly, we are looking forward to reinvigorating the momentum behind the improvement initiatives that pre-date COVID-19. We also eagerly anticipate the final report of the Royal Commission and look forward to playing a role in delivering to the Victorian community a more contemporary and responsive mental health system that better meets its needs and expectations.

Matthew Carroll
President

Membership changes during 2019-20

Over the course of 2019-20, two psychiatrist members and one legal member of the Tribunal retired. Beyond sitting on hearings, members contribute to the Tribunal in a variety of ways. We acknowledge the contribution of and say farewell to Dr Elizabeth Delaney, Dr Leon Fail and Mr Christopher Thwaites.

The terms of appointment of approximately half of the current members of the Tribunal expire in February 2021. This triggered a member appointment round, which commenced in January 2020. As always, there was significant interest and a large number of applications were received, with interviews being conducted during March and April 2020 by a panel comprising the Tribunal's Consumer and Carer Engagement Officer, Deputy President and President.

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 used in the treatment of an adult who does not have capacity to give informed consent to ECT, or 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 Act are reflected in the experience of consumers and carers.

Our mission

The Tribunal decides whether a person receives compulsory treatment under the Act. 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.

As a public authority under the Victorian *Charter of Human Rights and Responsibilities Act 2006* (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 doing so is consistent with the purpose of the Act.

PART ONE

Functions, procedures and operations of the Mental Health Tribunal

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

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

- an application for a Treatment Order to be made
- an application to revoke a Temporary Treatment Order or Treatment Order
- an application to review the transfer of a compulsory patient to another designated mental health service
- an application for an Order to allow electroconvulsive treatment to be used in the treatment of an adult who does not have capacity to give informed consent, or any person under the age of 18
- an application to perform neurosurgery for mental illness
- a range of applications and reviews to determine whether a person continues to satisfy the relevant criteria to be treated as a security patient
- an application by a security patient in relation to refusal 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
- applications about the proposed interstate transfer of a compulsory patient

and to perform any other function which is conferred on the Tribunal under the 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 of 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 receive the immediate treatment.

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 revoke the Order or make a new Treatment Order (setting the duration and category).

CASE STUDY

Determining whether a person has mental illness

The first criterion the Tribunal must consider is whether the person has mental illness. The Tribunal does not need to be satisfied that the person has a particular diagnosis; instead, it focuses on whether the person experiences significant symptoms that are indicative of a mental illness including ‘significant disturbances of thought, mood, perception or memory’ as defined in section 4(1) of the Act. The Act also includes a list of exclusions that in and of themselves are not indicative signs of a person having mental illness, including that a person is not considered to have mental illness by reason only that they have previously been treated for mental illness.

In *RMH* [2019] VMHT 25, the Tribunal was mindful of the obligation not to presume that a person has a mental illness only because they have previously been treated for mental illness.

RMH had been hospitalised a number of times displaying symptoms of a significant disturbance of thought and mood. During those admissions, he exhibited paranoia and persecutory delusions about people wishing to harm him and expressed grandiose beliefs including that he controlled everything, helped set up governments and could communicate with people by opening his mind. He also demonstrated significant disorganisation in his thinking and disturbances in his mood and had attempted to harm himself.

At the hearing, the treating team said RMH was not exhibiting active psychotic symptoms because his symptoms were well controlled with medication. RMH maintained his strongly held views that he did not have any mental illness and said that his previous admissions were the result of decisions he had made that were blown out of proportion by those around him. RMH referred to letters from his private psychiatrist and his GP which he said confirmed he wasn’t displaying any psychotic symptoms.

RMH’s legal representative submitted that RMH’s illness did not reach the requisite threshold of severity to constitute mental illness as defined in the Act and in light of the letters provided by his private psychiatrist and GP, there was insufficient evidence of RMH having mental illness.

The Tribunal found the letters provided by RMH’s private psychiatrist and GP were of limited assistance because the opinions expressed within them were based solely on their recent interactions with RMH. The Tribunal noted that while the letters confirmed RMH was not showing signs of psychosis when the letters were prepared, this was not disputed by the treating team. The real question was whether RMH’s lack of symptoms was due to him not having a mental illness, or because the symptoms were well controlled with medication. The Tribunal also noted RMH’s private psychiatrist was neutral regarding this question by noting that they did not have a more complete, ‘longitudinal picture’ of RMH’s mental health and conceding that with medication it was possible RMH’s symptoms were ‘adequately in remission’.

The Tribunal found that the legal submission that RMH’s symptoms did not reach the requisite threshold to meet the definition of mental illness focused too narrowly on his presentation while he was receiving treatment. This failed to engage with the description of his presentation during his previous hospital admissions.

Finally, the Tribunal considered RMH’s claim that he did not have a mental illness and that his past admissions were based on decisions that had been blown out of proportion. However, it had difficulty reconciling RMH’s explanations for his past admissions with the descriptions of how he presented at those times.

On the basis of RMH’s past psychiatric history, as well as his positive response to treatment, the Tribunal decided RMH had a medical condition characterised by a significant disturbance of thought.

Security patients

A security patient is a patient who is subject to either a Court Secure Treatment Order or a Secure Treatment Order.

A Court Secure Treatment Order (CSTO) is an Order made by a court to enable the person to be compulsorily taken to, and detained and treated in, a designated mental health service. A court may make a CSTO where the person is found guilty of an offence or pleads guilty to an offence and the relevant provisions specified in the sentencing legislation apply. The Order cannot exceed the period of imprisonment to which the person would have been sentenced had the Order not been made. Pursuant to s273 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives a security patient subject to a CSTO to determine whether the criteria for a CSTO apply to the security patient, and thereafter at no more than 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 s279 of the Act, the Tribunal is required to conduct a hearing within 28 days after the designated mental health service receives the security patient to determine whether the relevant criteria apply to the security patient, and thereafter at no more than 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 designated 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 used in the treatment of 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 (up to a maximum of six months) and the number of authorised ECT treatments (up to a maximum of 12).

For adults, whether they are on a Treatment Order or voluntary patients the Tribunal may only approve ECT if it is satisfied that:

- the person 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 psychiatrist making the application is satisfied that the course of ECT is necessary to save the person's life, prevent serious damage to their health or to prevent significant pain or distress.

CASE STUDY

Determining the setting of the Treatment Order – community vs inpatient treatment

If the Tribunal makes a Treatment Order, it must decide whether the person will receive treatment in hospital on an Inpatient Treatment Order or in the community on a Community Treatment Order. The Act does not list any considerations that must be taken into account; however, the Act says the Tribunal can only make an Inpatient Treatment Order if it is satisfied that treatment cannot occur in the community. When deciding the setting of an Order, the Tribunal will look at the circumstances in each case. The following examples highlight some of the considerations the Tribunal may have regard to when deciding the setting of an Order.

In *MTW* [2019] VMHT 39, the patient was on an Inpatient Temporary Treatment Order. However, MTW had left hospital on escorted leave the day before his hearing and had not returned. MTW's lawyer attended the hearing for him and said MTW agreed with the treating team's diagnosis and that he had a drug addiction; however, he didn't believe he needed any treatment. He preferred to be treated as a voluntary patient but acknowledged that this wasn't likely. If he had to be treated as a compulsory patient, he wanted to be treated in the community and to receive his depot (injectable) medication at home.

The treating team said if MTW had not absconded, the plan was to discharge him from hospital within a few days of the hearing. MTW was receiving depot medication in addition to oral medication and he was not due for another injection until a week after the hearing. The treating team acknowledged that after not returning from leave, MTW rang his case manager and left a message to apologise for not returning to the ward. The clinical notes of a mental state examination the day before the hearing recorded that MTW had no formal thought disorder, his judgment was reasonable, he wasn't responding to internal stimuli and he had insight into his condition.

The Tribunal was satisfied the treatment criteria applied to MTW and made a Treatment Order. In deciding the setting of the Order, the Tribunal considered the evidence before it which showed MTW's mental state had improved significantly during his admission. MTW was receiving stable medication and was not due for another injection for a week. His symptoms had settled and when his doctor reviewed him the day before the hearing, he was friendly and engaged. MTW's lawyer said MTW was frustrated about being in hospital when he was well and expressed a clear preference to be treated in the community if he had to be a compulsory patient.

The Tribunal was satisfied that MTW could be treated in the community and made a Community Treatment Order. The Tribunal did not condone MTW absconding from hospital but said if MTW had still been in hospital at the time of the hearing, the Tribunal would have made a Community Treatment Order. In addition, the Tribunal noted MTW's decision to contact his case manager showed regret about the way he left and an intention to engage with the treating team in the community. Importantly, the Tribunal said there was no practical reason why MTW could not receive appropriate follow up and treatment in the community.

In *MGP* [2020] VMHT 6, the patient had a long treatment history dating back to the early 2000s. More recently, this included several hospital admissions: some of these admissions were associated with times when MGP had decided not to take medication, others were triggered by changes to MGP's medication which regrettably led to the re-emergence of significant mood and psychotic symptoms.

At the time of the hearing, MGP was being treated as an inpatient after her Treatment Order had been varied to an Inpatient Treatment Order. During her hospital admission, MGP exhibited elevated mood, lability of mood, underlying irritability, agitation and disorganised thought form, as well as persecutory and grandiose delusions.

MGP did not dispute that she had a mental illness or that she needed immediate treatment. However, the treating team said MGP only superficially accepted her diagnosis and the need for treatment and did not demonstrate an understanding of her illness, its symptoms or the role of medication in keeping her well.

The treating team said MGP was still exhibiting active symptoms and she was not yet at her baseline. In the treating team's view, she needed to be supported in an inpatient setting to stabilise her medication, limit access to illicit substances and minimise external stressors. The treating team said that due to the ongoing disturbances in MGP's mood and thinking, it was not possible to safely manage her illness in the community.

The treating team planned to discharge MGP into the community shortly after the hearing because she had recently improved after her medication was changed. However, they wanted to see a further resolution of MGP's delusional thoughts and to engage her in drug and alcohol counselling before she was discharged.

MGP said she was committed to stopping her drug use and agreed that it had contributed to her missing appointments with her treating team. MGP agreed the treating team's plan was reasonable, but she wanted to go home and receive treatment in the community. She said each hospital admission occurred because a neighbour complained about her and made up allegations about her, not because she had been using drugs.

After speaking to MGP and considering the treating team's evidence, the Tribunal was satisfied that MGP was still exhibiting symptoms of acute illness and required ongoing support and treatment in an inpatient setting. The Tribunal accepted that because of her acute symptoms, MGP had difficulty understanding the reasons for her recent hospital admission and the importance of the treatment she was receiving in hospital. The Tribunal also considered that her recent history of multiple hospital admissions indicated that her next discharge required a clear, and thorough plan to support MGP in continuing with her treatment in the community, especially as the circumstances preceding MGP's recent admissions had exposed her to significant risk and could also jeopardise her accommodation. The Tribunal therefore made an Inpatient Treatment Order.

1.1.3 Neurosurgery for mental illness (NMI)

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

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

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

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

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

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

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

1.2 Administrative procedures

This section provides details of the Tribunal's approach to listings and hearings prior to 23 March 2020. From that date, the Tribunal's listing procedures and mode of hearing changed significantly in response to COVID-19. See section 'The Tribunal and the COVID-19 pandemic' for details of our operational response to COVID-19 and the impact on our functions.

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.

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 videoconference 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 videoconferencing 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, a 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 well over 8,000 hearings per year, it is not possible to case manage all matters. All cases are listed in accordance with the Tribunal's *List Management Policy and Procedure*. Case management is an additional process applied to priority cases to support the participation of patients, carers and nominated persons, and to facilitate the readiness of the matter to proceed on the date of hearing. Categories of matters that are case managed include:

- any matter that has previously been adjourned
- hearings where the circumstances require the matter to be finalised urgently
- matters involving complexity and that may require an extended hearing, such as hearings for patients who have had an exceptionally long period of inpatient treatment
- hearings relating to a patient who has had their 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 Mental Health Complaints Commissioner.

In conjunction with the Tribunal Advisory Group (see Part Three), work continues on reviewing 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.

CASE STUDY

Dealing with errors in Temporary Treatment Orders (jurisdictional issues)

If a person is being treated on a Temporary Treatment Order, the Tribunal must have a hearing before the Temporary Treatment Order expires. Occasionally, the Tribunal encounters errors in Temporary Treatment Orders. In previous Tribunal decisions including *VUZ* [2016] VMHT 64 and *YFC* [2016] VMHT 44, the Tribunal had regard to the principles set down in *Project Blue Sky v Australian Broadcasting Authority* (1988) 194 CLR 355 in deciding whether the errors in the Temporary Treatment Order meant the Tribunal did not have jurisdiction to proceed with the hearing. Recently in *KND* [2020] VMHT 4, the Tribunal decided there was a preferable approach to this issue.

KND was receiving compulsory treatment subject to a Temporary Treatment Order. When the authorised psychiatrist completed the Temporary Treatment Order, they failed to tick a box on the form to nominate whether KND was on a Community Temporary Treatment Order or an Inpatient Temporary Treatment Order. They also failed to tick the boxes to indicate whether they had regard to the considerations listed in section 48(2) of the Act, including KND's views and preferences and his reasons.

At the start of the hearing, KND's lawyer submitted that the errors in the Temporary Treatment Order rendered it invalid and therefore KND was not a compulsory patient so the hearing could not proceed.

In deciding whether the Tribunal had jurisdiction to proceed, the Tribunal looked at the language in sections 46 and 53 of the Act. It noted these sections consistently refer to a person who is or has been 'subject to' an Order and says nothing about the Tribunal's jurisdiction being dependent upon the validity or otherwise of the Order. The Tribunal considered it was '*inherently unlikely that Parliament intended that an authorised psychiatrist considering whether to make a Temporary Treatment Order would be constrained by, and empowered to consider, whether a Court Assessment Order was validly made. Plainly it would be inappropriate for either the authorised psychiatrist or the Tribunal to conduct an inquiry into or refuse to exercise its jurisdiction where a court had purported to make such an order*'.

The Tribunal then compared section 53 with section 187 of the Act, which provides a mechanism for refusing an application that doesn't comply with the requirements of the Act. The Tribunal noted section 53 doesn't have similar constraints for Orders that don't comply with procedural requirements and the mechanism for refusing an application in section 187 does not extend to Orders.

The Tribunal concluded that the terms of the provisions governing the Tribunal's role are imperative. Section 53 says the Tribunal '*must conduct a hearing to determine whether to make a Treatment Order…in relation to a person who is subject to a Temporary Treatment Order*'. This means the Tribunal's jurisdiction depends upon the person being subject to an Order, not the validity of that Order. Failure to tick a box on the Temporary Treatment Order does not affect the Tribunal's duty to conduct a hearing under section 53 of the Act. This meant KND was a compulsory patient at the time of the hearing and the Tribunal had to conduct a hearing in accordance with section 53.

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 ECT or NMI. 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 way 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 procedural fairness
- 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 consumers.
- 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, professional development opportunities for members are provided during the year including a members' forum, twilight seminar and practice reflection groups. The Members Performance Feedback Framework continued through the first half of this year. This is the process by which members undertake self-appraisal and are given comprehensive, structured feedback from their peers about how they approach their role in hearings. This feedback identifies training and professional development needs for individual members and the membership as a whole. The feedback cycle planned for January-June 2020 was suspended in March, due to the impact of the COVID-19 pandemic. The Tribunal plans to restart Members Performance Feedback in 2020-21.

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 additional person who was notified of the hearing – for example, a nominated person, a guardian or a carer.

1.3.5 Review by VCAT

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

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

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

1.3.6 Statements of reasons

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

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

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

When the statement of reasons 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 of reasons 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 involve 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.

1.4 Working with our stakeholders

1.4.1 Feedback

The Tribunal has a feedback and complaints framework which is available on the 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 Activity Reports provide a summary of issues raised in complaints or feedback we have received. This year the Tribunal also conducted its second Tribunal Hearing Experience survey – see Part Three for more information.

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 several 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 regular and ad-hoc communications with a wide range of other bodies, including:

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

1.4.3 Educational activities

This year the Tribunal finalised a comprehensive education strategy to guide all our educative work – both internal and external (see Part Three for details). In accordance with the strategy, the Tribunal undertakes a range of activities to explain its role and the framework for treatment established by the Act. This includes offering local education sessions for all health services at least once a year and the delivery of papers and presentations to a variety of audiences. 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.

One of the many impacts of the COVID-19 pandemic was the suspension of education activities from March 2020. We will recommence these activities at the appropriate time, and we are also exploring how we might undertake this work differently in the future.

1.4.4 Increasing transparency – new Quarterly Activity Report

In quarter one of 2019-20 the Tribunal introduced an expanded quarterly report. The Quarterly Activity Report provides all the data previously covered in the Key Performance Indicators report, but with changes to enhance the accessibility and detail of the data, and the addition of basic demographic information including the gender, age and location of people for whom we are conducting hearings. Quarterly Activity Reports are published on our website.

CASE STUDY

Applying the principles of the Act in Secure Treatment Order hearings – sections 4(2)(o) and 11(1)(h)

In *GJL* [2020] VMHT 9, GJL was receiving treatment under a Secure Treatment Order. In deciding whether GJL had mental illness, the Tribunal had regard to the definition of mental illness including that people are not considered to have mental illness by reason only that they have previously received treatment for mental illness. It also had regard to the mental health principle that Aboriginal persons should have their distinct culture and identity recognised and responded to.

GJL is an Aboriginal man who was first diagnosed with a mental illness in his late teens and since then had received treatment on a number of occasions. However, there continued to be significant uncertainty about his diagnosis and his treating team wanted to review and reconsider his diagnosis.

GJL's behaviour in prison had been very disturbed. He was preoccupied with themes of being illegally detained and was thought disordered with prominent cultural and political themes. When placed on his current Order he was floridly psychotic, highly irritable and agitated and required seclusion. However, his symptoms settled with the introduction of treatment.

GJL disputed that he had a mental illness that required treatment with medication. He said that his strongly held beliefs about the oppression of Aboriginal people had been misinterpreted by others as a sign of mental illness. He expressed frustration that he was misinterpreted as being grandiose or having persecutory delusions whenever he raised strong concerns about the history of Indigenous oppression. He also said nothing was explained to him when he was placed on the Order and he believed he had a right to refuse treatment, so he got angry when the treating team tried to force him to have treatment.

GJL's lawyer submitted that the treating team relied heavily on past notes and GJL should not be presumed to have mental illness by reason only that he had previously received treatment for mental illness. She said GJL's refusal and anger over forced treatment was understandable given he wasn't aware of his changed legal status and the reported symptoms of GJL being irritable and angry were contextually appropriate and not necessarily a sign of mental illness. She also said that his improved mental state was not necessarily evidence of the medication treating a mental illness, as opposed to GJL calming down as he gained more understanding and control over his situation. She also noted that GJL had recently been assessed as fit to stand trial.

In reaching its decision, the Tribunal acknowledged the treating team's concerns that GJL had experienced previous episodes of illness. However, the Tribunal had difficulty reconciling this with GJL's presentation in the hearing. He was calm and considered and didn't show active symptoms of mental illness and it was unclear the extent to which his calm demeanour could be attributed solely to the medication.

The Tribunal acknowledged that Aboriginal people will experience jail as especially distressing. GJL was a passionate and committed advocate in relation to issues of Indigenous oppression, including incarceration, and the Tribunal accepted that GJL's past diagnosed personality disorder could explain the intensity of his behaviour whilst in custody.

In the end, the Tribunal placed weight on the supportive evidence provided by GJL's mother, as well as the limited evidence of GJL displaying symptoms of psychosis outside custodial settings. After a lengthy deliberation, the Tribunal decided there was insufficient evidence before it to be satisfied that GJL had a mental illness within the meaning of section 4 of the Act. Therefore, the Tribunal ordered that GJL be discharged as a security patient and returned to prison. This meant GJL could make his own decisions about treatment.

The Tribunal and the COVID-19 pandemic

On 11 March 2020, the World Health Organisation declared coronavirus (COVID-19) could be characterised as a pandemic. On 16 March 2020, Victoria declared an 'unprecedented' state of emergency to respond to the COVID-19 outbreak and on 30 March 2020 introduced Stage 3 Stay-at-Home restrictions, sending the state into a limited 'lockdown'. Various limits on movement, activities, businesses and public and private gatherings have been in force in Victoria since March 2020, affecting the day-to-day operations of health-related organisations, services and businesses across the state.

Friday 20 March 2020 was the last day the Tribunal was able to conduct in-person hearings at Victoria's mental health inpatient units and community mental health clinics. Ordinarily, the Tribunal conducts more than 75% of its hearings in-person, with the remainder being conducted by video conference using the private, point-to-point video link the Tribunal has with each inpatient unit and clinic.

The immediate consequences of this were not limited to the mode by which hearings could be held, our hearing capacity was also reduced by approximately 60%. Under business as usual, each day up to 10 Tribunal divisions attend hospitals and clinics in metropolitan Melbourne and regional Victoria. It was impossible to immediately relocate these divisions at the Tribunal's offices. There was also insufficient infrastructure to immediately support hearings where people needed to participate from a variety of different locations. In addition, our procedures and systems were paper based.

Taking immediate action

Like many organisations responding to the fast-moving COVID-19 situation, the Tribunal had to act quickly. We had to immediately develop a policy to guide the allocation of our limited hearing capacity across all the hearings that needed to be conducted in accordance with patients' rights and the Tribunal's obligations under the Act. With the COVID-19 restrictions in place, it was initially impossible to conduct all hearings that were needed. We decided to list hearings in accordance with a priority ranking framework, based on the framework of the Act and taking into consideration the Tribunal's obligations as a public authority under the Charter:

Priority 1
ECT applications for adults unable to give informed consent and patients under 18 years old to ensure ECT remained available for these patients.

Priority 2
Hearings about a Treatment Order for patients who had not had a Tribunal hearing during their current episode of treatment.

Priority 3
Hearings about a Treatment Order for patients who had had a Tribunal hearing during their current episode of treatment.

We also developed a COVID-19 action plan with three phases:

Phase 1 Increasing our capacity to conduct all required hearings by teleconference.

Phase 2 Implementing paperless processes to maximise the Tribunal's flexibility and capacity to conduct fully remote teleconference hearings (that is, with all participants participating from separate locations, including their own home if necessary, and in a scenario where the Tribunal potentially lost access to its offices).

Phase 3 Adopting an online videoconference platform to enable fully remote video hearings.

Progress and highlights

The Tribunal re-established its capacity to conduct all required hearings by 27 April 2020.

In the five weeks when we were unable to conduct all required hearings, a range of listing strategies and the combined efforts of all parties meant we were able to limit the number of missed hearings to 108. While this doesn't diminish the impact on the people whose hearings were missed, it was significantly less than first anticipated.

The shift to electronic processes was progressed quickly, including:

- implementing e-processes for the distribution of materials prior to hearings by 26 March 2020
- designing e-processes for the finalisation of determinations and Orders by 4 May 2020 and implementing these progressively
- completing e-training for all registry staff (15) and members (121) to access e-materials by 5 June 2020.

As new processes were being introduced, the Tribunal and our stakeholders were especially concerned about the potential impact of teleconference hearings on levels of participation and this aspect of our changed operations was monitored closely. For the three months of 2019-20 affected by the pandemic:

- Patients participated in 60% (1,269) of hearings. They did not participate in 847 hearings. This is an increase on the average patient attendance rate for the past three years of 3%.
- Family participated in 15% (326) of hearings. They did not participate in 1,790 hearings. Over the previous three years family have on average attended 18% of hearings.
- Carers participated in 4% (84) of hearings. They did not participate in 2,032 hearings. This is 1.5% below the average carer attendance rate for the past three years of 5.5%.
- Nominated persons participated in 2% (39) of hearings. They did not participate in 2,077 hearings. Over the previous three years nominated persons have on average attended in 2.5% of hearings.

In terms of our three-phase action plan, at 30 June 2020 the Tribunal is close to completing Phase two. Some scoping work has been undertaken in relation to Phase three and the introduction of online video hearings.

The Tribunal acknowledges that some hearing participants want us to move quickly to adopt video platforms. However, we also recognise that an enormous amount of change has been introduced in a very short time in relation to our processes and hearings, much of which has occurred (due to the circumstances) with little and often no consultation. The Tribunal's view is that we need to properly embed our new systems, consult with stakeholders and investigate issues of usability and access prior to introducing a video platform. We are also in the process of recruiting and training the additional registry staff needed to support our current hearing model (whether the mode is telephone or video) given the vastly increased level of administrative co-ordination that is needed. Further changes to our registry processes are also needed to support video hearings, which require additional time to design and implement. This work will be a priority in the early part of 2020-21.

PART TWO

Hearing statistics for 2019-20

In this year's Annual Report the Tribunal is presenting much of the data in three parts – the year as a whole, then broken down into two periods, 1 July 2019 to 22 March 2020 and 23 March 2020 to 30 June 2020. The split effectively separates data between pre and post COVID-19 in order to enable a very preliminary and basic identification of any impacts of the pandemic and our revised processes.

Key statistics at a glance * ^

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Hearings listed **	13,564	13,603	**12,770**	**9,869**	**2,901**
Hearings conducted	8,280	8,635	**8,786**	**6,670**	**2,116**
Decision made	7,521	7,751	**7,761**	**5,844**	**1,917**
Adjourned	759	884	**1,025**	**826**	**199**
Treatment Orders made	6,127	6,297	**6,226**	**4,673**	**1,553**
Temporary Treatment Orders / Treatment Orders revoked	340	497	**531**	**386**	**145**
ECT Orders made	682	592	**539**	**410**	**129**
ECT applications refused	80	98	**78**	**62**	**16**
NMI hearings conducted	8	1	**4**	**3**	**1**
Statement of reasons requested	228	246	**178**	**137**	**41**
Applications to VCAT	39	27	**31**	**23**	**8**

* *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 required a hearing.*

^ *Figures for 2017-18 and 2018-19 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

Attendance at hearings[1]

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Patients	4,753	4,825	**5,041**	**3,773**	**1,268**
Family members	1,464	1,528	**1,543**	**1,217**	**326**
Carers	547	438	**375**	**291**	**84**
Nominated persons	222	249	**196**	**157**	**39**
Medical treatment decision-makers	8	27	**35**	**25**	**10**
Support persons	0	0	**1**	**0**	**1**
Interpreters	444	365	**433**	**346**	**87**
Legal representatives	1,213	1,162	**1,157**	**865**	**292**

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

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 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 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 is counted as one hearing and one outcome.

2.1 Treatment Orders

2.1.1 Outcomes of hearings regarding Treatment Orders

In 2019-20, the Tribunal made a total of 6,226 Treatment Orders and revoked 531 Temporary Treatment Orders and Treatment Orders. There were a small number of matters where the Tribunal found it did not have jurisdiction to conduct a hearing (3) and 106 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 and tables provide a breakdown of the total number of Orders made and revoked, the category of Orders made (that is, whether they were Community or Inpatient Treatment Orders) and the duration of Orders.

Figure 1: *Determinations regarding Treatment Orders*

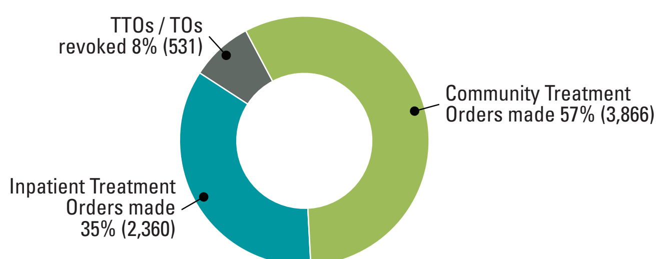


Table 1: *Determinations regarding Treatment Orders*

	2017–18		2018–19		**2019–20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Community Treatment Orders made	3,547	54%	3,835	57%	**3,866**	**57%**	2,857	56%	1,009	59%
Inpatient Treatment Orders made	2,580	40%	2,462	36%	**2,360**	**35%**	1,816	36%	544	32%
Temporary Treatment Orders / Treatment Orders revoked	340	6%	497	7%	**531**	**8%**	386	8%	145	9%
Total Treatment Orders made or revoked	6,467	100%	6,794	100%	**6,757**	**100%**	5,059	100%	1,698	100%

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

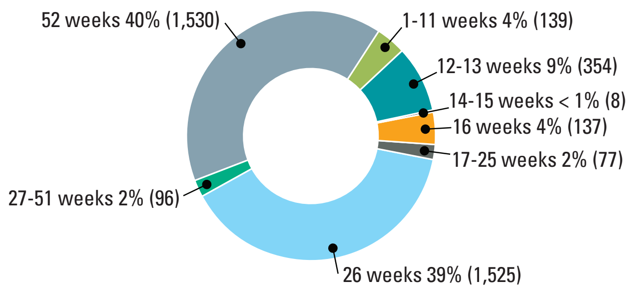


***Table 2:** Duration of Community Treatment Orders made*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
1-11 weeks	151	4%	139	4%	**139**	**4%**	104	4%	35	3%
12-13 weeks	313	9%	412	11%	**354**	**9%**	268	9%	86	9%
14-15 weeks	14	0%	14	0%	**8**	**< 1%**	4	< 1%	4	< 1%
16 weeks	116	3%	153	4%	**137**	**4%**	104	4%	33	3%
17-25 weeks	82	2%	69	2%	**77**	**2%**	61	2%	16	2%
26 weeks	1,259	36%	1,442	37%	**1,525**	**39%**	1,090	38%	435	43%
27-51 weeks	101	3%	109	3%	**96**	**2%**	79	3%	17	2%
52 weeks	1,511	43%	1,497	39%	**1,530**	**40%**	1,147	40%	383	38%
Total	3,547	100%	3,835	100%	**3,866**	**100%**	2,857	100%	1,009	100%

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

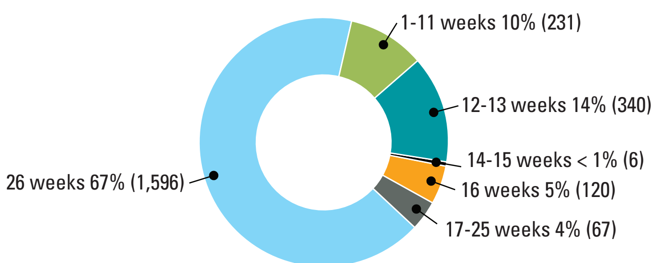


***Table 3:** Duration of Inpatient Treatment Orders made*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
1-11 weeks	311	12%	270	11%	**231**	**10%**	182	10%	49	9%
12-13 weeks	344	13%	392	16%	**340**	**14%**	269	15%	71	13%
14-15 weeks	10	< 1%	6	< 1%	**6**	**< 1%**	5	< 1%	1	< 1%
16 weeks	95	4%	128	5%	**120**	**5%**	96	5%	24	4%
17-25 weeks	90	4%	81	3%	**67**	**4%**	62	4%	5	1%
26 weeks	1,730	67%	1,585	65%	**1,596**	**67%**	1,202	66%	394	73%
Total	2,580	100%	2,462	100%	**2,360**	**100%**	1,816	100%	544	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 tables 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 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*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Community Treatment Orders made	1,316	42%	1,352	42%	**1,545**	**47%**	1,079	45%	466	52%
Inpatient Treatment Orders made	1,654	52%	1,580	50%	**1,475**	**44%**	1,130	47%	345	38%
Temporary Treatment Orders revoked	189	6%	249	8%	**288**	**9%**	202	8%	86	10%
Total Treatment Orders made or revoked	3,159	100%	3,181	100%	**3,308**	**100%**	2,411	100%	897	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 **

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Treatment was able to be provided in a less restrictive manner	77%	69%	**79%**	76%	86%
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%	**6%**	6%	5%
Immediate treatment was not able to be provided	12%	15%	**10%**	11%	8%
The person did not have a mental illness	4%	9%	**5%**	7%	1%
Total	100%	100%	**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*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Community Treatment Orders made	2,002	82%	2,245	81%	**2,132**	**80%**	1,633	80%	499	80%
Inpatient Treatment Orders made	345	14%	349	13%	**367**	**14%**	282	14%	85	14%
Temporary Treatment Orders / Treatment Orders revoked	97	4%	172	6%	**155**	**6%**	114	6%	41	6%
Total Treatment Orders made or revoked	2,444	100%	2,766	100%	**2,654**	**100%**	2,029	100%	625	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 **

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Treatment was able to be provided in a less restrictive manner	65%	78%	**74%**	75%	72%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	18%	8%	**10%**	8%	19%
Immediate treatment was not able to be provided	12%	11%	**11%**	14%	0%
The person did not have a mental illness	5%	3%	**5%**	3%	9%
Total	100%	100%	**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*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Community Treatment Orders made	336	43%	359	43%	**377**	**47%**	266	44%	111	57%
Inpatient Treatment Orders made	384	50%	376	46%	**338**	**42%**	277	45%	61	31%
Temporary Treatment Orders / Treatment Orders revoked	53	7%	88	11%	**92**	**11%**	69	11%	23	12%
Total Treatment Orders made or revoked	773	100%	823	100%	**807**	**100%**	612	100%	195	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 **

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Treatment was able to be provided in a less restrictive manner	77%	59%	**68%**	66%	76%
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	13%	19%	**14%**	15%	12%
Immediate treatment was not able to be provided	5%	10%	**6%**	6%	4%
The person did not have a mental illness	5%	12%	**12%**	13%	8%
Total	100%	100%	**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*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Community Treatment Orders made	83	13%	105	16%	**78**	**12%**	58	12%	20	13%
Inpatient Treatment Orders made	536	82%	501	76%	**522**	**80%**	399	79%	123	81%
Treatment Orders revoked	35	5%	56	8%	**56**	**8%**	47	9%	9	6%
Total Treatment Orders made or revoked	654	100%	662	100%	**656**	**100%**	504	100%	152	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 **

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Treatment was able to be provided in a less restrictive manner	15%	23%	**12%**	12%	11%
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%	**3%**	4%	0%
Immediate treatment was not able to be provided	75%	67%	**85%**	84%	89%
The person did not have a mental illness	5%	5%	**0%**	0%	0%
Total	100%	100%	**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 2019-20 the Tribunal heard a total of 610 applications for an electroconvulsive treatment (ECT) Order. Four hundred and seventy-seven ECT Orders were made for adult compulsory patients and 74 applications were refused. Fifty-five ECT Orders were made in relation to adults being treated as voluntary patients and four applications were refused.

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

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
	No.	No.	No.	No.	No.
Compulsory adult patient					
ECT Orders made	672	539	**477**	366	111
ECT applications refused	79	98	**74**	58	16
Voluntary adult patient					
ECT Orders made	9	43	**55**	38	17
ECT applications refused	1	0	**4**	4	0
ECT Orders made and applications refused	761	680	**610**	466	144

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*

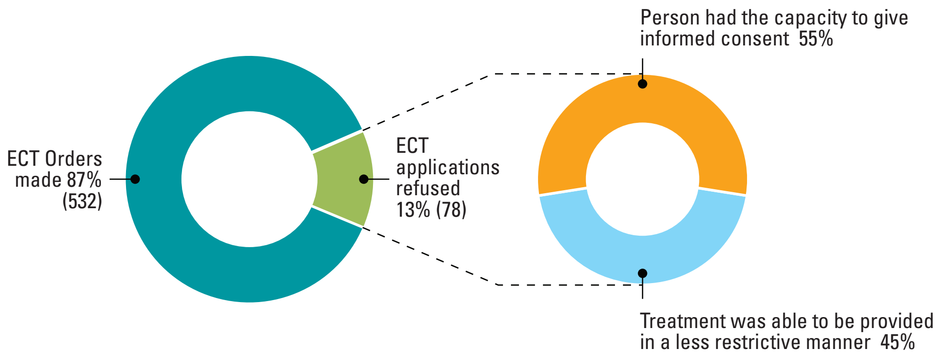


Table 13: *Determinations regarding ECT applications*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
ECT Orders made	681	89%	582	86%	**532**	**87%**	404	87%	128	89%
ECT applications refused	80	11%	98	14%	**78**	**13%**	62	13%	16	11%
Total ECT Orders made or applications refused	761#	100%	680*	100%	**610^**	**100%**	466	100%	144	100%

 # Two additional ECT applications were determined as no jurisdiction and two ECT applications were struck out.
** One additional ECT application was determined as no jurisdiction.*
^ Five additional ECT applications were struck out.

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

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Treatment was able to be provided in a less restrictive manner	65%	61%	**45%**	48%	37%
Patient had the capacity to give informed consent	34%	39%	**55%**	52%	63%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	1%	0%	**0%**	0%	0%
Total	100%	100%	**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*

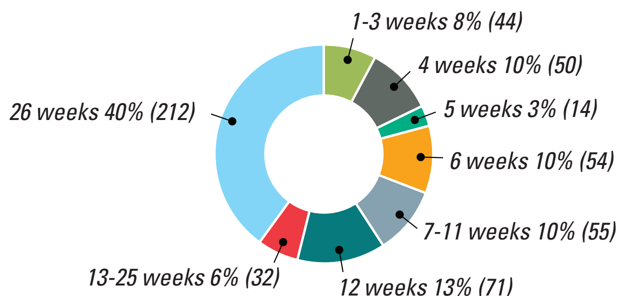


Table 15: *Duration of ECT Orders*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
1–3 weeks	80	12%	53	9%	**44**	**8%**	37	9%	7	5%
4 weeks	85	12%	66	11%	**50**	**10%**	31	8%	19	15%
5 weeks	10	1%	4	1%	**14**	**3%**	12	3%	2	1%
6 weeks	79	12%	57	10%	**54**	**10%**	42	10%	12	9%
7–11 weeks	79	12%	50	9%	**55**	**10%**	40	10%	15	12%
12 weeks	110	16%	71	12%	**71**	**13%**	55	14%	16	13%
13–25 weeks	45	7%	72	12%	**32**	**6%**	26	6%	6	5%
26 weeks	193	28%	209	36%	**212**	**40%**	161	40%	51	40%
Total	681	100%	582	100%	**532**	**100%**	404	100%	128	100%

Figure 6: *Number of ECT treatments authorised*

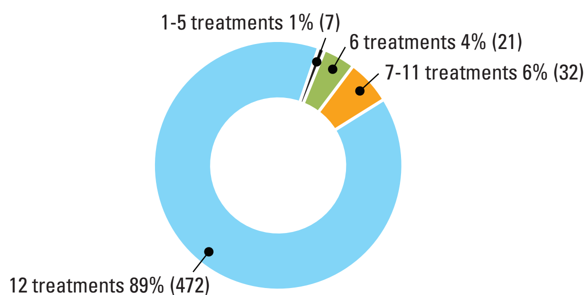


Table 16: *Number of ECT treatments authorised*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
1–5 treatments	13	2%	11	2%	**7**	**1%**	6	1%	1	1%
6 treatments	40	6%	34	6%	**21**	**4%**	13	3%	8	6%
7–11 treatments	66	10%	54	9%	**32**	**6%**	22	6%	10	8%
12 treatments	562	82%	483	83%	**472**	**89%**	363	90%	109	85%
Total	681	100%	582	100%	**532**	**100%**	404	100%	128	100%

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

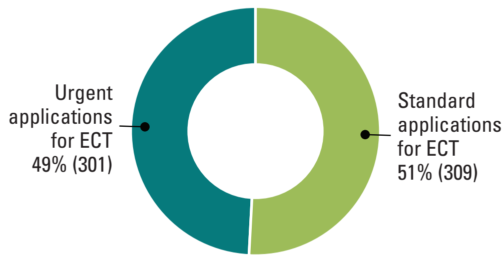


Table 17: *Proportion of applications for ECT Orders that were urgent*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Urgent applications for ECT	439	58%	360	53%	**301**	**49%**	225	48%	76	53%
Standard applications for ECT	322	42%	320	47%	**309**	**51%**	241	52%	68	47%
Total ECT applications	761	100%	680	100%	**610**	**100%**	466	100%	144	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 2019-20, the Tribunal heard three urgent after-hours ECT applications. All three 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. 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, 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*

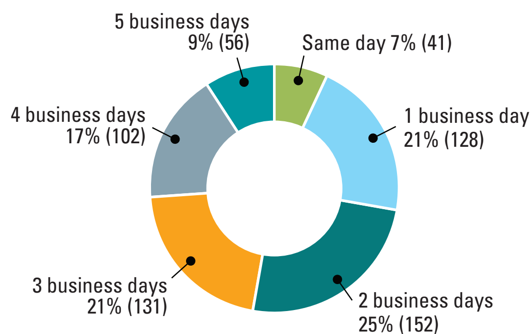


Table 18: *Elapsed time from receipt of ECT applications to hearing*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Same day	104	14%	52	8%	**41**	**7%**	32	7%	9	6%
1 business day	216	28%	145	21%	**128**	**21%**	93	20%	35	24%
2 business days	179	24%	196	29%	**152**	**25%**	119	25%	33	23%
3 business days	124	16%	136	20%	**131**	**21%**	103	22%	28	20%
4 business days	84	11%	105	16%	**102**	**17%**	79	17%	23	16%
5 business days	50	7%	43	6%	**56**	**9%**	40	9%	16	11%
Total	757	100%	677	100%	**610**	**100%**	466	100%	144	100%

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

Compulsory patients

During 2019-20, 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 2019-20, the Tribunal received four 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*

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
	No.	No.	No.	No.	No.
Compulsory patients – ECT Orders made					
Patient's age: 13	1	0	**0**	0	0
Patient's age: 14	0	1	**0**	0	0
Patient's age: 16	0	0	**1**	1	0
Patient's age: 17	0	2	**2**	2	0
Voluntary patients – ECT Orders made					
Patient's age: 14	0	2	**1**	1	0
Patient's age: 15	0	2	**2**	2	0
Patient's age: 16	0	0	**1**	0	1
Patient's age: 17	0	3	**0**	0	0
Total	1	10	**7**	6	1

2.4 Neurosurgery for mental illness

During 2019-20, the Tribunal received four applications to perform neurosurgery for mental illness (NMI). All applications were granted.

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

Application	Applicant mental health service	Diagnosis	Proposed Treatment	Location of patient	Hearing outcome
1	Royal Melbourne Hospital, Neuropsychiatry Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted
2	Royal Melbourne Hospital, Neuropsychiatry Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted
3	Royal Melbourne Hospital, Neuropsychiatry Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted
4	St Vincent's Hospital NMI Unit	Obsessive compulsive disorder	Deep brain stimulation	Victoria	Granted

2.5 Security patients

During 2019-20, the Tribunal made 99 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*

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
	No.	No.	No.	No.	No.
Hearings for a security patient					
28-day review					
Remain a security patient	69	75	**89**	72	17
Discharge as a security patient	2	1	**3**	3	0
Six-month review					
Remain a security patient	6	5	**4**	3	1
Discharge as a security patient	0	0	**0**	0	0
Application for revocation by or on behalf of the patient					
Remain a security patient	3	5	**2**	1	1
Applications struck out	0	0	**1**	1	0
Total	80	86	**99**	80	19
Application by a security patient regarding leave					
Applications granted	0	0	**0**	0	0
Applications refused	0	0	**0**	0	0
Total	0	0	**0**	0	0

2.6 Applications to review the transfer of patient to another service

During 2019-20, the Tribunal received six 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*

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Applications granted	1	4	**0**	0	0
Applications refused	4	3	**5**	4	1
No jurisdiction	0	1	**1**	1	0
Total	5	8	**6**	5	1

2.7 Applications to transfer a patient interstate

During 2019-20 there were no applications received by the Tribunal to transfer a patient interstate.

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

	2017-18	2018-19	**2019-20**
Applications granted	0	2	**0**
Applications refused	1	0	**0**
Total	1	2	**0**

2.8 Applications to deny access to documents

During 2019-20, the Tribunal received 165 applications to deny access to documents.

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

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Applications granted	54	55	**128**	105	23
Applications refused	16	9	**31**	20	11
Applications struck out	1	3	**5**	4	1
No jurisdiction	1	0	**1**	1	0
Total	72	67	**165**	130	35

2.9 Applications for review by VCAT

During 2019-20, 31 applications were made to VCAT for a review of a Tribunal decision.

Table 25: *Applications to VCAT and their status*

	2017-18	2018-19	**2019-20**
Applications made	39	27	**31**
Applications withdrawn	18	11	**13**
Applications struck out	0	0	**1**
Applications dismissed	1	0	**5**
Hearings vacated	0	3	**2**
Decision set aside by consent	1	0	**0**
No jurisdiction	-	2	**0**
Applications proceeded to full hearing and determination	13	10	**13**
Applications pending at 30 June	6	4	**3**

Table 26: *Outcomes of applications determined by VCAT*

	2017-18	2018-19	**2019-20**
Decisions affirmed	13	8	**12**
Decisions varied	0	1	**0**
Decision set aside and another decision made in substitution	0	0	**1**
Orders revoked	0	1	**0**

2.10 Adjournments

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

The Tribunal cannot adjourn a hearing to a date that is after the date on which a patient's current Treatment Order expires unless the Tribunal is satisfied that exceptional circumstances exist. If exceptional circumstances do exist, the Tribunal may extend the duration of the patient's Temporary Treatment Order or Treatment Order, but only for a 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*

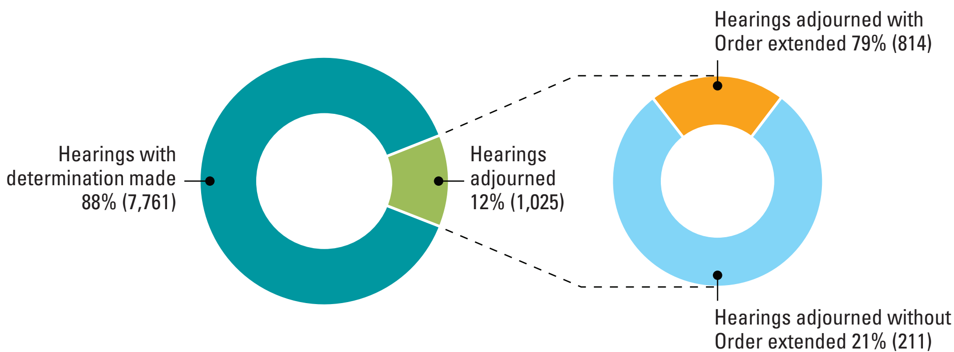


Table 27: *Hearings adjourned*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Hearings adjourned without Order extended	180	24%	172	19%	**211**	**21%**	184	22%	27	14%
Hearings adjourned with Order extended	579	76%	712	81%	**814**	**79%**	642	78%	172	86%
Total	759	100%	884	100%	**1,025**	**100%**	826	100%	199	100%
Hearings adjourned as a percentage of total hearings conducted	9%		10%		**12%**		12%		9%	

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

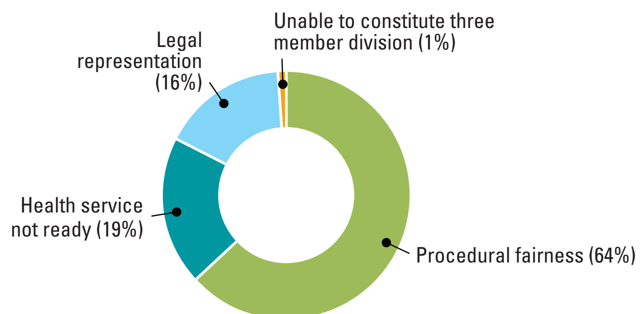


Table 28: *Reasons for adjournments with extension of Order*

	2017-18	2018-19	**2019-20**	July 2019 to March 2020	March to June 2020
Procedural fairness - patient participation or other support *	–	–	**47%**	45%	52%
Procedural fairness - enable access to report / file *	–	–	**11%**	10%	16%
Procedural fairness (other)	56%	60%	**6%**	3%	16%
Health service not ready - report not prepared *	–	–	**6%**	7%	3%
Health service not ready – transfer *	–	–	**5%**	6%	1%
Health service not ready - treating team attendance *	–	–	**7%**	7%	5%
Health service not ready (other)	29%	20%	**1%**	2%	< 1%
Legal representation	15%	20%	**16%**	19%	7%
Unable to constitute three-member division *	–	–	**1%**	1%	< 1%
Adjourn as application to deny access to documents refused	< 1%	0%	**0%**	0%	0%
Total	100%	100%	**100%**	100%	100%

** Additional reasons for adjournment with extension of Order were added on 1 July 2019 and direct comparisons with previous years cannot be made*

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 s189 of the Act, the Tribunal must provide notice of the hearing to the patient, the patient's parent if they are under the age of 16, the authorised psychiatrist and the following persons if applicable:

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

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

Table 29: *Number and percentage of hearings with the patients and support people in attendance*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Patient	4,753	57%	4,826	56%	**5,042**	**57%**	3,773	57%	1,269	60%
Family member	1,464	18%	1,528	18%	**1,543**	**18%**	1,217	18%	326	15%
Carer	547	7%	438	5%	**375**	**4%**	291	4%	84	4%
Nominated person	222	3%	249	3%	**196**	**2%**	157	2%	39	2%
Medical treatment decision-maker	8	< 1%	27	< 1%	**35**	**< 1%**	25	< 1%	10	< 1%
Support person	0	0%	0	0%	**1**	**< 1%**	0	0%	1	< 1%
Interpreter	444	5%	365	4%	**433**	**5%**	346	5%	87	4%
Legal representative	1,213	15%	1,162	13%	**1,157**	**13%**	865	13%	292	14%

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 2019-20.

Table 30: *Legal representation at hearings*

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Victoria Legal Aid	1,065	13%	1,003	12%	**1,009**	**11%**	752	11%	257	12%
Mental Health Legal Centre	95	1%	123	1%	**103**	**1%**	73	1%	30	1%
Private Lawyer	39	1%	28	< 1%	**31**	**< 1%**	27	1%	4	< 1%
Other Community Legal Centre	14	< 1%	8	< 1%	**14**	**< 1%**	13	< 1%	1	< 1%
Total legal representation	1,213	15%	1,162	13%	**1,157**	**13%**	865	13%	292	14%

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 2019-20. First episode psychosis was added as a diagnosis in 2019-20, and direct comparisons with previous years cannot be made.

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

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
Schizophrenia	3,884	47%	4,122	48%	**4,067**	**46%**	3,068	46%	999	47%
Schizo-Affective disorder	1,854	22%	1,903	22%	**1,969**	**22%**	1,458	22%	511	24%
Bipolar disorder	784	10%	792	9%	**848**	**10%**	622	9%	226	11%
Depressive disorders	362	4%	296	3%	**280**	**3%**	225	3%	55	3%
Delusional disorder	164	2%	181	2%	**180**	**2%**	141	2%	39	2%
Dementia	45	1%	39	< 1%	**42**	**1%**	34	1%	8	< 1%
No diagnosis recorded	278	3%	401	5%	**444**	**5%**	387	6%	57	3%
Other organic disorders	11	< 1%	12	< 1%	**13**	**< 1%**	10	< 1%	3	< 1%
Eating disorders	44	1%	68	1%	**72**	**1%**	52	1%	20	1%
Other	853	10%	821	10%	**513**	**6%**	411	6%	102	5%
First episode psychosis	-	-	-	-	**358**	**4%**	262	4%	96	4%
Total	8,279	100%	8,635	100%	**8,786**	**100%**	6,670	100%	2,116	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. Since 23 March 2020, all hearings have been conducted by telephone, with ancillary video in a small number of matters where available.

***Table 32:** Hearings conducted by mode**

	2017-18		2018-19		**2019-20**		July 2019 to March 2020		March to June 2020	
	No.	%	No.	%	No.	%	No.	%	No.	%
In-person	6,303	76%	6,627	77%	**5,213**	**59%**	5,213	78%	0	0%
Video conference	1,972	24%	1,978	23%	**1,425**	**16%**	1,425	21%	-*	-*
Teleconference	11#	< 1%#	34	< 1%	**2,148**	**25%**	32	1%	2,116	100%
Totals hearings conducted	8,286	100%	8,639	100%	**8,786**	**100%**	6,670	100%	2,116	100%

 # On some occasions, both video and teleconference facilities were used to enable parties to participate in hearings.
** Complete data about the number of hearings conducted by video between 23 March and 30 June 2020 is not available.*

2.14 Compliance with statutory deadlines

A key element of the Registry's listing procedures is to ensure that a hearing will be conducted within the relevant timeframe specified in the Act. In a small number of matters statutory deadlines are missed.

Table 33: *Hearings not conducted within statutory deadlines*

Not conducted within statutory deadlines	Count
Hearing unable to proceed because the patient's Treatment Order had expired #	6
Hearing adjourned by the Tribunal to be heard out of time *	32
Hearing conducted out of time ^	15
Hearing unable to be conducted because of capacity constraints due to COVID-19	108
Total	161

 # three instances were due to an error on the part of the Tribunal, three because the Tribunal was not notified of the relevant Order until after it had expired.

** occasionally the Tribunal will knowingly adjourn a matter to a date that is after the relevant statutory deadline, most commonly this is done where it is necessary to afford a patient procedural fairness.*

^ some matters can be heard even when the applicable statutory deadline is missed, two of these delayed hearings were attributable to a Tribunal error, three arose because of an error on the part of a health service, 10 delays were a consequence of the impact of the COVID-19 pandemic.

2.15 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 two business days, unless the enquiry is complex and/or requires investigation and cannot be fully responded to within that timeframe. In 2019-20, the Tribunal responded to 92% of phone calls within 15 seconds and responded to all email and website enquiries in accordance with the Service Charter.

The Tribunal's Registry aims to send Treatment Orders and ECT Orders to relevant parties within five working days of a hearing. In 2019-20, the Tribunal achieved this target 64% of the time.

Table 34: *Sending Treatment and ECT Orders to relevant parties*

	2017-18	2018-19	**2019-20**
Percentage of Orders sent to parties within five working days of a hearing	54%	57%	**64%**
Average number of days to send Orders to parties	6 days	6 days	**6 days**

PART THREE

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 and
- 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 principle of allowing people to make decisions about their treatment and recovery that involve a degree of risk.

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 2020-21, including a brief update of projects that were interrupted by the COVID-19 pandemic.

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

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

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

Our Strategic Priorities

1 Ensuring fair, consistent and solution-focused hearings

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

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

This year the Tribunal has continued to work on maximising the participation of consumers and their support people in hearings as a means of achieving our vision, namely that the principles and objectives of the Act are reflected in the experiences of consumers and carers.

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. The role of the TAG is to provide strategic and operational advice to the Tribunal from the perspective of consumers and carers with lived experience.

TAG members are generally engaged for up to two terms of two years each, after which new members are recruited to bring renewal and new experience to the TAG. We aim to renew up to half of our TAG membership every two years to maintain a balance of experienced TAG members and new member perspectives.

In 2019-20 the TAG recruited four new members and four existing members re-nominated. The new TAG members we welcomed this year are:

- Mary Eckel - Carer Consultant
- William Lau - Consumer Consultant
- Peter McDonald – Carer
- Tracey Taylor - Consumer

Throughout 2019-20, the TAG continued to provide strategic and operational advice to the Tribunal and co-produced key initiatives supporting the participation of consumers and carers. Because of COVID-19, the TAG has been meeting virtually since March 2020.

One of the TAG's major activities this year has been to steward a 10-point Action Plan to increase attendance and participation at hearings (see box on the next page). This project came out of the first Tribunal Hearing Experience (THE) Survey and a workshop at our 2019 Consumer and Carer Forum. The Tribunal's Governance Group endorsed all the actions, most of which have been implemented or are well underway.

This year the TAG also:

- provided advice on how to improve the hearing report template
- led the development of plain-English templates for Tribunal determinations and Orders
- oversaw the 2019 Tribunal Hearing Experience (THE) Survey, including surveying non attendees for the first time (the results are available on our website)
- provided advice on two key strategic resources – the Tribunal's Education Strategy and the Tribunal's Consumer and Carer Engagement policy
- initiated a review of our Consumer and Carer engagement framework
- provided advice on the development of an improved Quarterly Activity Report.

Action plan to increase attendance and participation at hearings

Action 1: Work with health services to improve hearing notifications

Continue to support and influence health services to fulfil their responsibilities of:

- collecting and maintaining up-to-date records of patients and carers addresses and other contact details
- notifying inpatients of hearings and providing information about how to prepare.

Action 2: Notify and remind patients of hearings by text messages and email

Explore new and better ways to notify patients:

- have the state-wide mental health database changed to include patients' mobile phone numbers and email addresses
- trial sending SMS text messages to remind patients of their hearings
- trial notifying patients of hearings by email as well as by post.

Action 3: Tell patients how to request a change of hearing date

Modify notice of hearing letters to tell patients and carers they can contact the Tribunal to request a different hearing date.

Action 4: Stick to hearing times

Establish clear guidance for Tribunal Members and health services to ensure that they do not change the start time of hearings without confirming it suits all hearing participants.

Action 5: Recovery-focused report templates

Create recovery-focused report templates that make reports easy for patients to understand and respond to.

Action 6: Tell patients we will listen to them

Trial new notice of hearing letters communicating that Tribunal Members will listen to patients and consider what they say when making their decision.

Action 7: Health service support for patients to participate in hearings

Continue to engage with health services about how to support patients to participate in hearings.

Action 8: More guidance for carers on participation in hearings

Produce a video for family, friends and carers with guidance on how they can most effectively participate in hearings. We already have videos for patients.

Action 9: Tell patients who is attending the hearing

Change the Tribunal's notice of hearing letters to tell patients which of their support people have been notified of the hearing.

Action 10: Further promote interpreters and information in other languages

Continue to encourage health services to:

- let the Tribunal know when a patient or carer would like an interpreter at a hearing so that the Tribunal can arrange one
- provide patients who prefer to use other languages with the translated information on the Tribunal's website.

Pictured left to right:

Top row:
Fiona Smethurst, Ali Pain, William Lau

Middle row:
Julie McNamara, Troy Barty, Tracey Taylor

Bottom row:
Judith Drake, Jan Dundon, Mary Eckel

Not pictured:
Peter McDonald, Pauline Ferguson

3.1.2 Second Tribunal Hearing Experience (THE) Survey

The Tribunal conducted its second Tribunal Hearing Experience (THE) Survey in October 2019. The results of THE survey inform the Tribunal about how consumers and carers experience Tribunal hearings, highlight areas where the Tribunal is doing well and guide us on 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 2019-20, THE Survey was not only sent to all consumers, carers, nominated persons and other support people who attended a hearing, it was also sent to those who were notified of and invited to attend a hearing, but did not do so. The reason for this was to try and better understand barriers to attendance and participation and thereby identify opportunities to improve rates of attendance in the future. All survey responses were anonymous.

Dr Cheryl Reed of Health Community Consulting Group Pty Ltd analysed the survey results.

Key facts about this survey

- THE Survey was run in October 2019, the same month as the 2018 THE Survey
- 1059 eligible participants were invited to attend hearings
- 110 eligible participants completed THE Survey, a 10% response rate (the 2018 response rate was 21%). Of these, 15% were completed by attendees and 8% by non-attendees.

Conclusions

Dr Reed's analysis of THE Survey draws conclusions across four broad areas:

Performance

The Tribunal performed strongly at hearings and in activities the Tribunal has control over. Poorer performance was reported regarding accurate contact details for consumers and carers, the content of treatment reports and the provision of information such as worksheets.

Engagement

Participation in this year's survey was lower than expected and lower as a percentage of hearings than in 2018. More work is needed to promote THE Survey, encourage more responses and to get accurate contact details.

Attendance at hearings

Opportunities to attend hearings could be increased by better processes for informing people of hearing times, providing them with Tribunal information pamphlets and worksheets, and exploring opportunities to attend hearings via video or telephone.

Materials presented to the Tribunal

Materials prepared and presented by the health service can cause great concern if they are inaccurate. This could be addressed through health service education. Opportunities for consumers to provide written material in advance could also be considered.

The Tribunal has accepted these conclusions and will consider how to respond in 2020-21. The full report is available on the Tribunal's website: http://www.mht.vic.gov.au/news/findings-tribunals-hearing-experience-survey.

CASE STUDY

Consideration of the principles in Tribunal decisions

In preparing statements of reasons under the Act, the Tribunal aims to write primarily for the patient. This involves using plain language, avoiding the use of jargon and minimising references to case law. It also involves ensuring that the views and preferences of patients and their family members and carers are reflected in the reasons. As reported in last year's Annual Report, increasingly statements of reasons are being written to and for – rather than about – patients.

Clear and transparent statements of reasons provide a record of the issues discussed in the hearing, and an explanation for the Tribunal's decision. Often this will be relatively contained, focusing solely on the decision about whether or not the relevant statutory criteria applied in an individual patient's circumstances. However, statements of reasons can also capture discussion that occurred about broader issues such as a patient's physical health, broader social supports they may want and their recovery goals, which might be used to inform future treatment planning between a patient, their support people and the treating team. If a statement of reasons concerns a decision to make a Treatment Order, the statement of reasons may also record discussions that occurred about a potential pathway towards less restrictive and, ultimately, voluntary, treatment.

The statement of reasons in DHD [2020] VMHT 7 illustrates how the Tribunal incorporates the mental health principles in its decision-making process. In this case, the focus was on the principle that persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. This principle is often referred to as the 'dignity of risk' principle.

This case involved a consumer, DHD, with very complex needs and considerable risks, including a history of aggressive behaviour. DHD had been an inpatient at Thomas Embling Hospital for almost two years after her sentence had ended and was eager to leave hospital, go and live with her relatives and receive treatment in the community. In contrast, DHD's treating team felt DHD was not ready to go home and the first step was transition to a Secure Extended Care Unit (SECU) – a move that required careful planning and support. The Tribunal decided that the treatment criteria were met and the hearing – and the statement of reasons – centred mainly on whether DHD should be treated as an inpatient or in the community.

In its decision, the Tribunal set out the key mental health principles that were most relevant in this case. It stated everyone was concerned that DHD had been in Thomas Embling Hospital for such a long time after her sentence had ended and that it was very important that there be extensive efforts to end the limits on DHD's freedom and that this happen as quickly as possible. The decision emphasised that any ongoing restrictions on DHD must be the minimum necessary. In explaining the decision to DHD, the Tribunal explained how it weighed up these principles, particularly the principle of the dignity of risk:

'The Tribunal accepts that the right to take reasonable risks is important for a person's dignity and growth. This is sometimes referred to as the dignity of risk. 'Dignity of risk' is a concept that recognises that every decision or choice has an element of risk and there is potential for success or failure. Being able to make a decision that could result in failure or result in a backward step is an important part of a person's learning and recovery. The right to make a decision that might seem unreasonable to others is allowed and supported by the mental health principles. The Tribunal considers that in the context of treatment for mental illness and the principles of supported decision-making, reasonable supports should be provided to allow and manage some risks.

The Act does not use the term 'dignity of risk' but says a person should be able to make decisions that involve a degree of risk. The degree of risk that should be tolerated in each case must be based on that person and their individual situation. The degree of risk must be reasonable and sensible. The Tribunal is regularly weighing up many factors. These are the sorts of things the Tribunal took into account:

- *Is the risk to you or would others also be placed at risk?*
- *Risks to your relationships and the importance of those relationships to you now and in the future*
- *What are the risks? For example – is the risk that you would relapse and need admission to hospital, or is there a risk of offending or reoffending which could have more serious consequences for you?*
- *Could your accommodation options become more limited if the risks are not managed?*
- *The supports required to manage the risks – what supports are needed and are they available?*

The Tribunal weighed up your choices, the extent or degree of risks involved and the reasonableness of the risks. Importantly, it also took into account your views and preferences and your long-term goals. In your case you want to leave hospital now, and in the longer term you want to be able to live a more independent life. The Tribunal considers the risks now, how they could affect your ability to achieve your long-term goals and whether the risks can be managed.'

The Tribunal took into consideration the treating team's evidence that transition from Thomas Embling Hospital to a SECU and eventually the community was a complex process that needed to be progressed carefully to maximise the chance of success. It agreed DHD needed lots of support and help to leave Thomas Embling Hospital and to live the life she wanted. In the Tribunal's view, DHD was currently better able to manage her sometimes aggressive behaviours but that this was not always the case and that the treating team had the skills and resources to support her when she was frustrated and acting in this way. The Tribunal also took into account that:

- DHD had spent a lot of time in prison over many years and everyone wanted her to be able to avoid future offending and another prison sentence
- at the time of the hearing, the risks were not just to DHD, but also to other people, including her closest family, if she was not in hospital with the containment and support provided.

For this reason, the Tribunal was satisfied that treatment could not be provided in the community at the time of the hearing and made an Inpatient Treatment Order.

In this case, the 'degree of risk' at the time of the hearing was too great to allow DHD to go home. However, the Tribunal's reasoning sought to convey that, while the degree of risk was too great on this occasion, if some of the issues identified continued to be addressed and plans for transition continued to progress, there was a real pathway to less restrictive treatment in the future. By carefully considering DHD's preferences and long-term goals in its decision, the Tribunal also gave effect to the mental health principle that persons receiving mental health services be involved in all decisions about their assessment, treatment and recovery, that they be supported to make or participate in those decisions and that their views and preferences be respected.

3.2 Solution-focused hearings

Solution-focused hearings aim to engage hearing participants as active partners in the Tribunal's decision-making process. 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.

This year the Tribunal commenced work on consolidating into the one resource all the additional chapters that have been completed since the publication of the original Guide in 2014. These include chapters on responding to the needs of particular consumers and hearing participants in order to promote solution-focused hearings (comprising chapters on solution-focused hearings for young people, for older people and on involving family, friends, carers and other support people in hearings). The consolidated Guide will also contain a new Part on considering treatment issues and risk through the lens of solution-focused hearings. The Guide will also be fully revised and updated to reflect the Tribunal's experience of solution-focused hearings since 2014. It is expected that the new consolidated Guide will be completed during the 2020-21 financial year.

CASE STUDY

Example of a solution-focused hearing: Dany's hearing

Sometimes the patient and their carers or family members wish to talk about issues that may not be strictly, or only tangentially, related to the matters determined by the Tribunal. It is true that in endeavouring to be solution-focused the Tribunal must guard against 'issue creep.' At the same time, an appropriately contained discussion of issues that might otherwise fall within another forum (such as a complaints body) can be difficult to avoid. If such discussions are 'shut down' inflexibly, the Tribunal process can leave behind a magnified dispute.

The inquisitorial and informal nature of the Tribunal allows some scope to raise such issues so that a participant's primary concerns are respectfully acknowledged and, if unable to be addressed formally in a hearing, agreement reached about how these issues will be addressed after a hearing. This enhances the engagement of patients and their support people in hearings and helps them to feel that their voices are being heard – an essential feature of a solution-focused approach. It also reflects the mental health principles, particularly those around involving consumers in treatment decisions and supporting them to make or participate in those decisions, and respecting the rights, dignity and autonomy of consumers.

The example of 'Dany's' hearing shows how a constructive discussion of broader concerns can be an important part of a solution-focused hearing and influence the Tribunal's decision.

During Dany's hearing, Dany's family members raised their dissatisfaction with what they considered to be poor communication they had experienced, and their concerns regarding some specific aspects of Dany's care. For example, they provided background information and explained that, as Dany had been a victim of abuse, she reacted adversely to restraint and lacked trust in people she was not familiar with. Dany's family offered some guidance as to how to encourage Dany's adherence to treatment.

During the hearing, Dany's doctor also had an opportunity to respond to specific medication and nursing issues raised by Dany's family and provided his perspective on some of the complexities around Dany's health and treatment during her most recent admissions.

The Tribunal encouraged the treating team and Dany's family and friends to resolve their issues around communication. They supported the idea of establishing a single point of communication to avoid further difficulties and support Dany in her recovery. As part of this discussion, everyone at the hearing agreed that a referral to a dual disability service would be constructive.

The Tribunal decided to make a Treatment Order for a duration that was considerably less than the treating team's recommendation. The Tribunal noted that Dany had accepted and received treatment for many years previously without the need for a Treatment Order and expressed the hope that, once her mental health was more stable, Dany would once again be able to be treated on a voluntary basis.

3.3 The Tribunal's education strategy

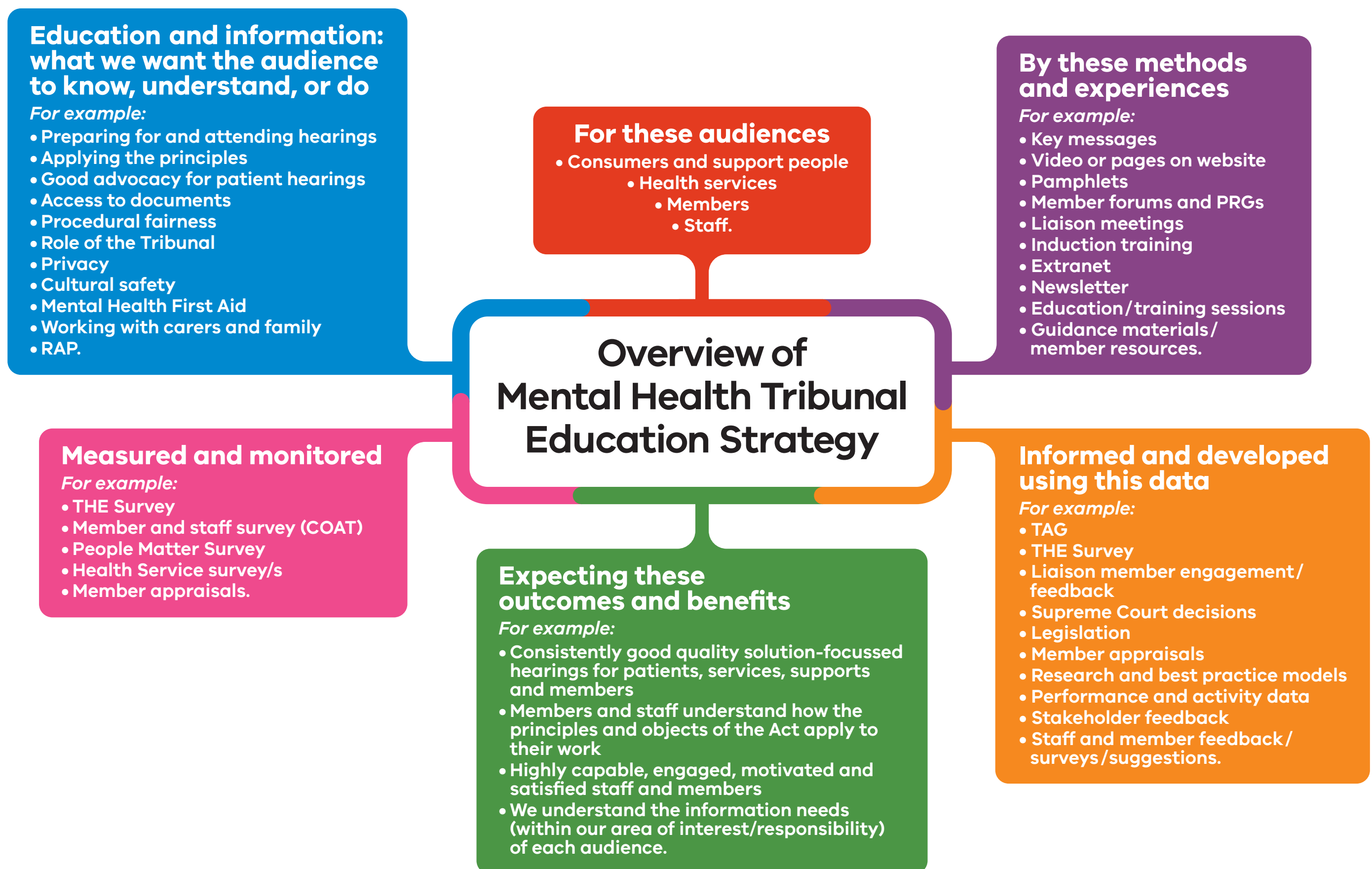
The Tribunal values and prioritises the education of members, staff and health services as an investment in the pursuit of our mission and vision, which focus on ensuring the principles and objectives of the Act are reflected in the experience of consumers and carers. The provision of high quality, accessible information for consumers and their support people is a priority for the Tribunal for the same reasons.

In previous years, we have focused on improving the quality and accessibility of information for consumers and carers. This year the Tribunal has introduced an education strategy to formalise a holistic, flexible and responsive approach to ensure we deliver accurate and consistent information, at the right time and in a range of accessible ways to each of our key audiences: consumers and their support people, health services, Tribunal members and Tribunal staff.

The strategy has six components:

During 2019-20 we have continued our education and information improvement program by adding content to the Tribunal's website (including information for carers and additional translations) and trialling more consumer-friendly notices of hearing and other hearing documentation.

During 2020-21 the Tribunal will focus on refining education activities and tools to better meet the needs of health services and members.



3.4 The Tribunal's engagement with the Royal Commission into Victoria's Mental Health System and the Productivity Commission's Mental Health Inquiry

Following the Tribunal's formal submission to the Royal Commission into Victoria's Mental Health System (highlighted in last year's Annual Report), in 2019-20 the Tribunal has continued to actively engage with the Commission. This year the Royal Commission has been exploring issues related to the Mental Health Act and compulsory treatment.

As part of this examination, the Tribunal's President, Matthew Carroll, was asked to provide a witness statement and participate in a virtual panel hearing with the Royal Commission. Other members of the panel were Professor Lisa Brophy, Dr Chris Maylea and Dr Ruth Vine.

The Tribunal is in a privileged position to observe the myriad of interactions between consumers, carers and the mental health system, where those interactions take place under the Act. In our initial submission to the Commission, the Tribunal used the principles of the Act to distil themes and systemic issues from those observations. The President's witness statement elaborated on some of those themes; for example, by highlighting that the frequent lack of continuity in the members of a compulsory patient's treating team means that the longitudinal relationships needed to understand a person's situation and engage with the principles of the Act often cannot be established, leaving a void that is frequently filled by compulsory Treatment Orders.

This year the Tribunal also made a brief submission to the federal Productivity Commission's Mental Health Inquiry. The submission was in response to the Productivity Commission's draft recommendation that the availability of legal services for people who have hearings before mental health tribunals be increased. In its submission, the Tribunal expressed its support for increased access to legal representation as a support that facilitates patients' participation in hearings and addresses power imbalances. However, the Tribunal queried the rationale for the recommendation and related analysis that was based on evidence asserting a correlation between legal representation and hearing outcomes.

The submission also highlighted the deliberate design of the Tribunal's hearing processes and associated information and resource materials (including our website) to be accessible to and cater for consumers who do not have legal representation. For example, in the hour allocated to standard hearings the Tribunal is able to conduct a solution-focused discussion, 'asking questions to understand the full breadth of a consumer's situation, including their goals and preferences and to explore how impediments to less restrictive treatment may be resolved'. The submission recognised that legal representatives are valuable contributors to this process, but also made it clear that it still happens when consumers are not represented.

3.5 Projects that were interrupted by the COVID-19 pandemic

The Tribunal's work on a number of projects was suspended in March 2020 due to the COVID-19 pandemic. The Tribunal is committed to recommencing work on the following initiatives as early as possible in 2020-21:

- Treatment Report Project
  the Tribunal is continuing work on a project to update the template for the Report on Compulsory Treatment that mental health services must prepare and give to the Tribunal and the consumer before Treatment Order hearings. The intended outcome is a report that is focused on the patient (rather than the Tribunal) as the primary audience, is shorter, easier to write and read and both future and recovery focused. Such a report will better meet the needs of all users and provide a platform for solution-focused hearings.
- Reconciliation Action Plan (RAP)
  as reported in last year's Annual Report, the Tribunal has been working on its Reflect RAP to help us enliven the mental health principle that Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to. Submission of the RAP to Reconciliation Australia and commencement of the activities flowing from it is now planned for 2020-21.
- Advocacy project
  engagement with Victoria Legal Aid and the Mental Health Legal Centre to explore the role of legal assistance and representation in Tribunal hearings. This project involves consultation and the exchange of information to explore effective legal representation in hearings, particularly how legal advocacy can further the objectives and principles of the Act and contribute to solution-focused and recovery-oriented hearings.

Given the uncertainty arising from COVID-19, the Tribunal also decided to defer the development of its proposed 2020-23 Strategic Plan until later in 2020-21. The current 2018-20 Strategic Plan will continue to guide our work in the interim.

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
Chief 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

	2019-20	2018-19	2017-18
TOTAL	**$10,372,077**	$9,877,592	$9,640,663

Expenditure

Full and part-time member salaries	**$1,640,080**	$1,693,225	$1,559,794
Sessional member salaries	**$4,523,247**	$4,315,542	$4,413,473
Staff Salaries (includes contractors)	**$1,956,181**	$1,821,447	$1,642,699
Total Salaries	**$8,119,508**	$7,830,214	$7,615,966
Salary On costs	**$1,259,696**	$1,256,896	$1,200,168
Operating Expenses	**$770,794**	$712,722	$653,266
TOTAL	**$10,149,998**	$9,799,832	$9,469,400
Balance	**$222,079**	$77,760	$171,263

**Please note the 2017-18 data has been updated to reflect some changes in staffing and operating costs, however the total and balance remain unchanged.*

Appendix B

Membership List as at 30 June 2020

The composition of the Tribunal includes 81 female and 58 male members, made up of four full-time members (the President, Deputy President and two Senior Legal Members), seven part-time members and 128 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 2025 *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 Members	
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
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 *(Retired 15 June 2020)*
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

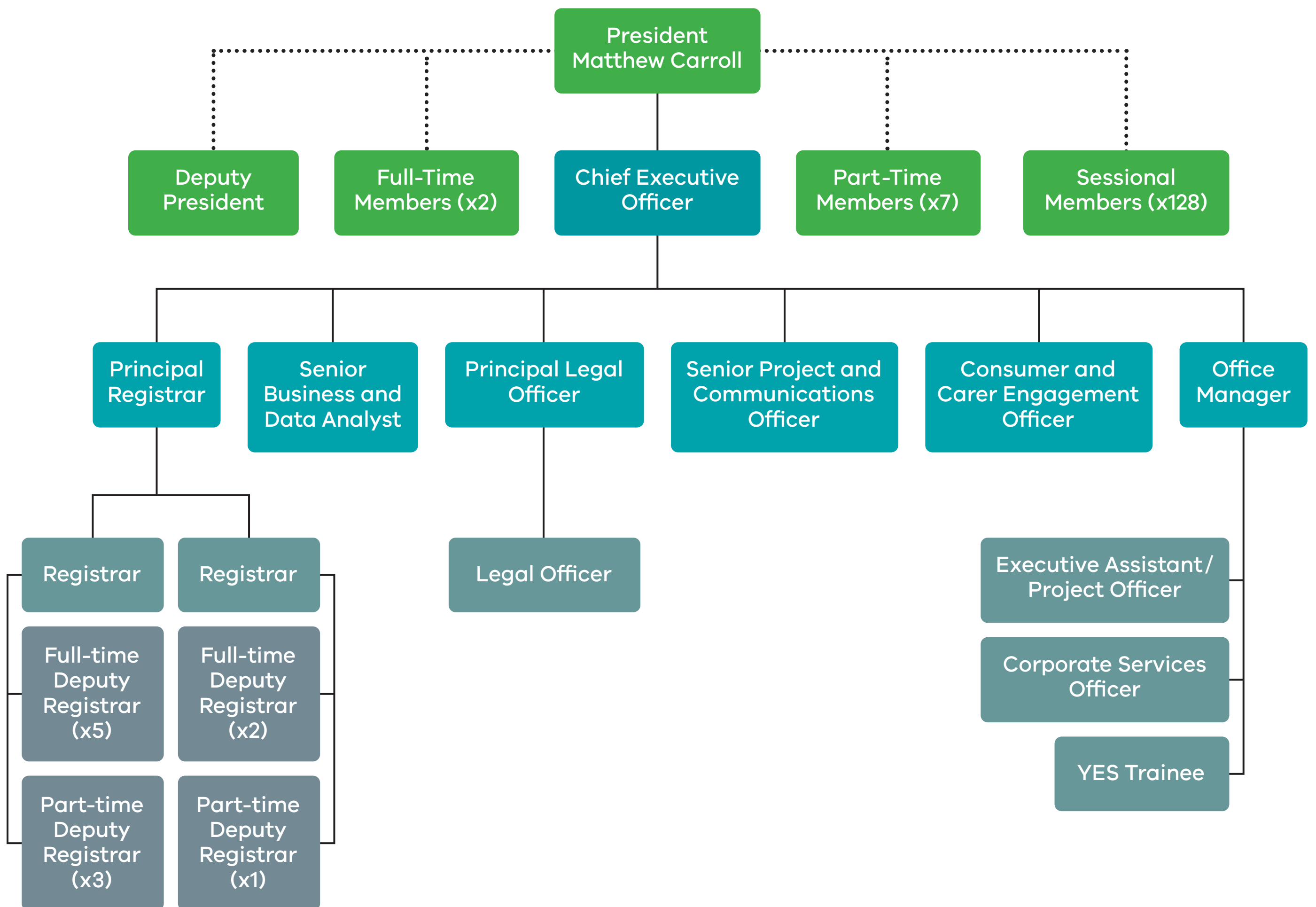
Psychiatrist Members	Period of Appointment
Dr Peter Adams	10 June 2018 - 9 June 2023
Dr Mark Arber	25 Feb 2016 - 24 Feb 2021
Dr Robert Athey	9 Oct 2012 - 24 Feb 2021
Dr Anthony Barnes	6 Nov 2019 - 9 June 2023 *(previously a Registered Medical Member 10 June 2018 – 5 Nov 2019)*
Dr David Baron	22 Jan 2003 - 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 *(Retired 1 June 2020)*
Dr Leon Fail	9 Oct 2012 - 24 Feb 2021 *(Retired 31 December 2019)*
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
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 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

Registered Medical Members	Period of Appointment
Dr Trish Buckeridge	1 July 2014 - 9 June 2023
Dr Louise Buckle	1 July 2014 - 9 June 2023
Dr Kaye Ferguson	25 Feb 2016 - 24 Feb 2021
Dr Naomi Hayman	1 July 2014 - 9 June 2023
Dr John Hodgson	1 July 2014 - 9 June 2023
Dr Helen McKenzie	1 July 2014 - 9 June 2023
Dr Sharon Monagle	1 July 2014 - 9 June 2023
Dr Sandra Neate	25 Feb 2016 - 24 Feb 2021
Dr Debbie Owies	1 July 2014 - 9 June 2023
Dr Stathis Papaioannou	1 July 2014 - 9 June 2023

Community Members	
Assoc Prof Lisa Brophy	10 June 2008 – 9 June 2023
Mr Duncan Cameron	10 June 2008 – 9 June 2023
Dr Leslie Cannold	10 June 2013 – 9 June 2023
Ms Katrina Clarke	10 June 2018 – 9 June 2023
Ms Paula Davey	29 Oct 2014 – 9 June 2023
Ms Robyn Duff	25 Feb 2011 – 24 Feb 2021
Ms Sara Duncan	10 June 2013 – 9 June 2023
Ms Angela Eeles	10 June 2018 – 9 June 2023
Mr Bernard Geary	10 June 2018 – 9 June 2023
Ms Jacqueline Gibson	10 June 2018 – 9 June 2023
Mr John Griffin	25 Feb 2011 – 24 Feb 2021
Prof Margaret Hamilton	25 Feb 2016 – 24 Feb 2021
Mr Ben Ilsley	10 June 2013 – 9 June 2023
Ms Erandathie Jayakody	10 June 2018 – 9 June 2023
Mr John King	1 June 2003 – 24 Feb 2021
Ms Danielle Le Brocq	10 June 2013 – 9 June 2023
Mr John Leatherland	25 Feb 2011 – 24 Feb 2021
Dr David List	25 Feb 2006 – 24 Feb 2021
Ms Anne Mahon	10 June 2013 – 9 June 2023
Assoc Prof Marilyn McMahon	19 Dec 1995 – 24 Feb 2021
Dr Kylie McShane	29 June 1999 – 24 Feb 2021
Ms Sarah Muling	25 Feb 2016 – 24 Feb 2021
Dr Patricia Mehegan	10 June 2008 – 9 June 2023
Ms Helen Morris	20 April 1993 – 24 Feb 2021
Ms Margaret Morrissey	25 Feb 2011 – 24 Feb 2021
Mr Aroon Naidoo	25 Feb 2016 – 24 Feb 2021
Mr Jack Nalpantidis	23 July 1996 – 24 Feb 2021
Ms Linda Rainsford	10 June 2013 – 9 June 2023
Ms Lynne Ruggiero	10 June 2013 – 9 June 2023
Mr Fionn Skiotis	25 Feb 2006 – 24 Feb 2021
Ms Veronica Spillane	25 Feb 2011 – 24 Feb 2021
Ms Helen Steele	25 Feb 2016 – 24 Feb 2021
Ms Charlotte Stockwell	10 June 2013 – 9 June 2023
Mr Anthony Stratford	10 June 2018 – 9 June 2023
Dr Penny Webster	25 Feb 2006 – 24 Feb 2021
Prof Penelope Weller	10 June 2013 – 9 June 2023

Appendix C

Organisational Chart as at 30 June 2020



Appendix D

Compliance reports

In 2019-20, 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 11 requests for access to documents. In four 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. Five of the requests were withdrawn or were not proceeded with, no documents were found in relation to one request and one request was handled as a formal FOI request.

How to lodge a request

The Tribunal encourages members of the public to contact the Tribunal before lodging a request under the FOI Act to ascertain if the documents may be released administratively. Otherwise, a freedom of information request must be made in writing and must clearly identify the documents being requested. 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 2019-20 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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