Mental Health Tribunal

MENTAL HEALTH TRIBUNAL

2020-21 ANNUAL REPORT

Protecting the rights and dignity
of people with mental illness

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Mental Health Tribunal

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17 August 2021

The Honourable James Merlino MP
Minister for Mental Health
Level 3, 1 Treasury Place
EAST 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 2020 to 30 June 2021.

Yours sincerely

Matthew Carroll
President

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PRESIDENT'S MESSAGE

The ongoing impact of the COVID-19 pandemic continued to fundamentally alter the operation of the Tribunal throughout 2020-21. Critically however, in the midst of this challenging environment, the Tribunal was able to conduct all hearings that were required under the *Mental Health Act 2014*.

Despite considerable work being carried out by the Tribunal to expand the options at our disposal, all hearings this year were conducted by teleconference (with a supplementary and partial video link for a small number of matters). While teleconference hearings do work, and are even preferred by some participants, we did not intend this to be our sole means of conducting hearings throughout the year.

Our last annual report explained that in accordance with our three-phase COVID-19 action plan, this year we would be focusing on phases two and three: streamlining processes and infrastructure for paperless, remote hearings; and introducing a platform for online video hearings. The refinement of our processes and infrastructure was very successful. Our new systems are robust and reliable and have enabled efficiencies and options previously unavailable under what were primarily paper-based systems. However, the introduction of online video hearings has proved extremely complicated.

Initially, we had hoped to use the platform employed for Telehealth consultations. It had the benefits of being well-established within health services and increasingly familiar to consumers and carers. Unfortunately, a technical assessment identified that the platform is not equipped to support the number of separate participants / connections involved in most Tribunal hearings. The Department of Health assisted the Tribunal with a further, comprehensive assessment of alternate platforms that examined technical issues, accessibility for users and administrative efficiency. After selecting a preferred system, we planned to commence a pilot of online video hearings in early June, but this had to be postponed. We are working to re-start the pilot as soon as possible.

Alongside the pilot, we are considering other strategies to expand the means by which we conduct hearings. While re-establishing a visual connection by video or in-person (when permitted) is our primary driver, it is not the only one. A very clear lesson from the last 12 months is that all Tribunal hearing participants appreciate flexibility and options, and for some, this can encourage them to attend when they might otherwise choose not to. Accordingly, we are exploring the feasibility of various hearing models and, as is almost universally the case for organisations across the country, we anticipate that our 'COVID-normal' operations will not be a facsimile of how we operated previously.

Despite the ongoing challenges of the pandemic, we were able to continue to pursue a range of critical improvements to Tribunal hearings. In January, we released a new template for hearing reports that was the result of collaborative work with our Tribunal Advisory Group (representing consumers and carers), health services and Tribunal members. The new template is designed to elicit the information that is required for hearings clearly and openly, but in a manner that isn't demoralising or distressing and that is focused on the future more than the past. It is also designed to be easier for clinicians to complete. This template was developed in response to clear feedback from all hearing participants and has been in use since March. As with all such changes, there is a settling in period and we will be reviewing the template and seeking feedback later in 2021.

The Tribunal also released the second edition of its *Guide to solution-focused hearings in the Mental Health Tribunal*. The Mental Health Act sets down the Tribunal's functions and the solution-focused framework continues as our point of reference for how we perform those functions – in particular, how to perform them in a manner that enlivens the Act's mental health principles. The fact that we have produced a second edition of this guide demonstrates that our effort to do this is ongoing, is never complete and we are always seeking ways to improve.

Undoubtedly, a highlight of 2020-21 was the release of the final report of the Royal Commission into Victoria's Mental Health System. The scope of the reforms to be implemented over the next 10 years is extraordinary. Alongside all other stakeholders, at the time of finalising this report the Tribunal is also finalising its contribution to the *Mental Health and Wellbeing Act: Update and Engagement Paper*. While the Royal Commission deferred any significant changes to the Tribunal until the review of the new Act in five to seven years, I want to reassure all those who have an interest in the work of the Tribunal that while there are no immediate structural and operational changes, we are enthused to be part of the cultural change that needs to start now. As we have done over the past seven years, we will continue to work collaboratively with consumers, carers and health services to promote the aspirations and comply with the obligations that will be enshrined in the new Mental Health and Wellbeing Act.

For all of us, 2020-21 has been a difficult year involving challenges that it would have been hard to imagine less than 18 months ago. Despite these challenges, the dedicated staff and members of the Tribunal have maintained an unwavering focus on ensuring the work of the Tribunal is performed to the highest possible standard. Our Tribunal Advisory Group members have continued to guide our work when there were doubtless many other demands on their time. Consumers and carers have trusted us enough to have deeply personal conversations with three faceless people over the telephone. Health service staff and legal representatives have continued to engage with the Tribunal and to help facilitate hearings in difficult conditions. Thank you all so much.

Matthew Carroll
President

Despite the ongoing challenges of the pandemic, we were able to continue to pursue a range of critical improvements to Tribunal hearings.

Membership changes during 2020-21

Over the course of 2020-21, several members retired and a number of members completed their term of appointment. We acknowledge the contribution of and say farewell to:

Community members
- Mr Bernard Geary
- Dr David List
- Prof Marilyn McMahon
- Ms Helen Morris
- Ms Margaret Morrissey
- Mr Fionn Skiotis
- Mr Anthony Stratford.

Legal members
- Prof Ian Freckelton
- Ms Carmel Morfuni
- Ms Jan Slattery
- Ms Camille Woodward
- Prof Spencer Zifcak.

Psychiatrist members
- Dr Joe Black
- Prof Malcolm Hopwood
- Dr Ahmed Mashhood
- Dr Sudeep Saraf
- Dr Rosemary Schwarz.

Registered medical member
Dr Louise Buckle.

A member appointment round was finalised in October 2020. In February 2021, we welcomed six new legal members, seven new psychiatrist members, two new registered medical members and five new community members. See Appendix C for the full list of members.

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 or people on remand who have been transferred to a designated mental health service for compulsory treatment)
- 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

Our obligations under the Charter of Human Rights and Responsibilities

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 1 | 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 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).

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 or remand period.

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.

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.

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 for patients of 57 venues, generally on a weekly or fortnightly basis. During 2020-21 the ongoing impact of the COVID-19 pandemic has meant all hearings have been conducted remotely by teleconference. For a small proportion of matters, some participants (usually the patient, the treating team and one of the three Tribunal members) have had a supplementary video connection.

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.

In addition, since May 2021, where the Tribunal has the mobile phone details for patients and carers they are sent a message advising of the hearing via SMS text.

1.2.4 Case management

As the Tribunal conducts well over 9,000 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 are 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.

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.

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 members' forums, twilight seminars and practice reflection groups. The Members Performance Feedback Framework recommenced in the second 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.

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. The registry prepares a determination for the parties on the day of hearing and sends it to the health service via email the same day.

If an Order is made, within five working days from the hearing the Tribunal's Registry will prepare and send the determination and 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 and feedback we have received.

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 engages with health services at multiple levels. Our 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.

During 2020-21 the Principal Registrar commenced regular meetings with the contact officers in health services. Known as the Tribunal Working Group (TWG), these meetings are chaired by the Principal Registrar. See Part Three for more information.

Other engagement activities

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

- Department of Health
- VMIAC
- Tandem
- Mental 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

The ongoing impact of COVID-19 restrictions meant that only a small number of education sessions were delivered to health services this year. The education support that was provided focused on the introduction of new templates for hearing reports (see Part Three for details).

1.4.4 Quarterly Activity Report

The Tribunal is committed to transparency about its work. Quarterly Activity Reports with data about the decisions we make are published at the end of quarters one, two and three and are available on our website.

The ongoing impact of COVID-19 restrictions meant that only a small number of education sessions were delivered to health services this year.

PART 2 | HEARING STATISTICS FOR 2020-21

Key statistics at a glance*^

	2020-21	2019-20	2018-19
**Hearings listed ** **	**13,337**	12,769	13,602
Hearings conducted	**9,543**	8,786	8,635
Decisions made	**8,212**	7,761	7,751
Adjourned	**1,331**	1,025	884
Treatment Orders made	**6,679**	6,226	6,297
Temporary Treatment Orders / Treatment Orders revoked	**546**	531	497
ECT Orders made	**539**	539	592
ECT applications refused	**80**	78	98
NMI hearings conducted	**3**	4	1
Statement of reasons requested	**238**	178	236
Applications to VCAT	**26**	31	27

* *The figures in Parts 2.1 to 2.8 represent determinations at substantive hearings and exclude hearings that were adjourned or finalised 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 2018-19 and 2019-20 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

Attendance at hearings[1]

	2020-21	2019-20	2018-19
Patients	**5,956**	5,042	4,826
Family members	**1,712**	1,544	1,522
Carers	**373**	372	440
Nominated persons	**250**	195	246
Medical treatment decision makers	**25**	37	31
Support persons	**2**	0	0
Interpreters	**455**	433	364
Legal representatives	**1,255**	1,157	1,162

1. Attendance of patients includes instances where the Tribunal visited the patient on the ward – not applicable in 2020-21.

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 2020-21, the Tribunal made a total of 6,679 Treatment Orders and revoked 546 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 (8) and 112 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*

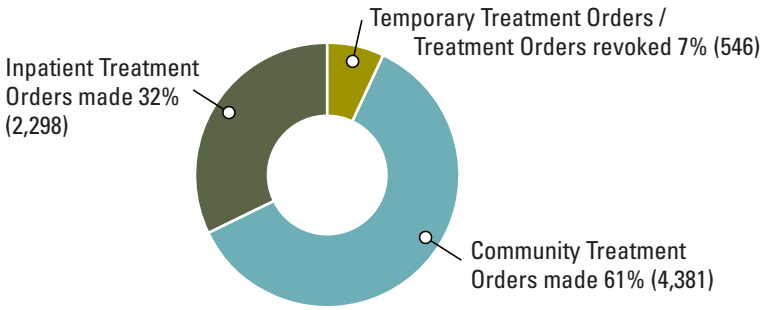


Table 1: *Determinations regarding Treatment Orders*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Community Treatment Orders made	**4,381**	**61%**	3,865	57%	3,835	57%
Inpatient Treatment Orders made	**2,298**	**32%**	2,361	35%	2,462	36%
Temporary Treatment Orders / Treatment Orders revoked	**546**	**7%**	531	8%	497	7%
Total Orders made or revoked	**7,225**	**100%**	6,757	100%	6,794	100%

Figure 2: *Duration of Community Treatment Orders made*

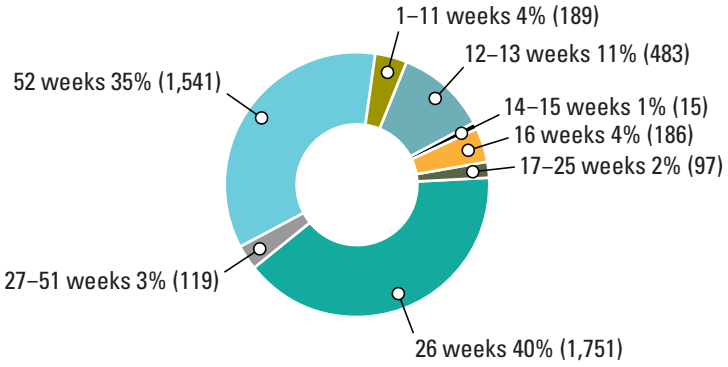


Table 2: *Duration of Community Treatment Orders made*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
1–11 weeks	**189**	**4%**	139	4%	139	4%
12–13 weeks	**483**	**11%**	354	9%	412	11%
14–15 weeks	**15**	**1%**	8	< 1%	14	< 1%
16 weeks	**186**	**4%**	137	4%	153	4%
17–25 weeks	**97**	**2%**	77	2%	69	2%
26 weeks	**1,751**	**40%**	1,524	39%	1,442	37%
27–51 weeks	**119**	**3%**	96	2%	109	3%
52 weeks	**1,541**	**35%**	1,530	40%	1,497	39%
Total	**4,381**	**100%**	3,865	100%	3,835	100%

Figure 3: *Duration of Inpatient Treatment Orders made*

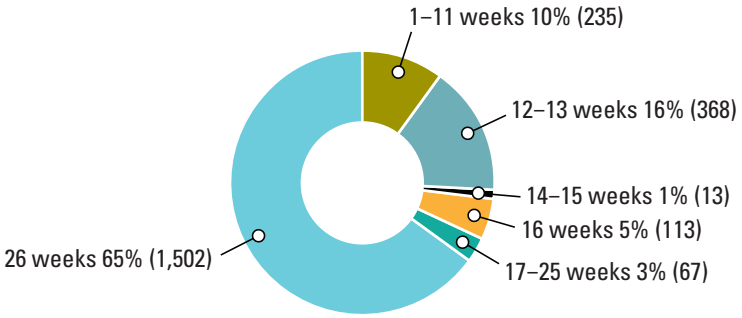


Table 3: *Duration of Inpatient Treatment Orders made*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
1–11 weeks	**235**	**10%**	231	10%	270	11%
12–13 weeks	**368**	**16%**	340	14%	392	16%
14–15 weeks	**13**	**1%**	6	<1%	6	<1%
16 weeks	**113**	**5%**	120	5%	128	5%
17–25 weeks	**67**	**3%**	66	3%	81	3%
26 weeks	**1,502**	**65%**	1,598	68%	1,585	65%
Total	**2,298**	**100%**	2,361	100%	2,462	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*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Community Treatment Orders made	**1,532**	**46%**	1,544	47%	1,352	42%
Inpatient Treatment Orders made	**1,481**	**45%**	1,476	44%	1,580	50%
Temporary Treatment Orders revoked	**289**	**9%**	288	9%	249	8%
Total Treatment Orders made or revoked	**3,302**	**100%**	3,308	100%	3,181	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 **

	2020–21	2019–20	2018–19
Treatment was able to be provided in a less restrictive manner	**85%**	79%	69%
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	**4%**	6%	7%
Immediate treatment was not able to be provided	**6%**	10%	15%
The person did not have a mental illness	**5%**	5%	9%
Total	**100%**	100%	100%

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

Applications for a Treatment Order by the authorised psychiatrist

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

Table 6: *Outcomes of authorised psychiatrist application hearings*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Community Treatment Orders made	**2,534**	**83%**	2,132	80%	2,245	81%
Inpatient Treatment Orders made	**353**	**11%**	367	14%	349	13%
Treatment Orders revoked	**175**	**6%**	155	6%	172	6%
Total Treatment Orders made or revoked	**3,062**	**100%**	2,654	100%	2,766	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 **

	2020–21	2019–20	2018–19
Treatment was able to be provided in a less restrictive manner	**81%**	74%	78%
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%**	10%	8%
Immediate treatment was not able to be provided	**8%**	11%	11%
The person did not have a mental illness	**4%**	5%	3%
Total	**100%**	100%	100%

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

Applications for revocation by or on behalf of a patient

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

Table 8: *Outcomes of revocation hearings*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Community Treatment Orders made	**541**	**59%**	376	47%	359	43%
Inpatient Treatment Orders made	**297**	**32%**	339	42%	376	46%
Temporary Treatment Orders / Treatment Orders revoked	**87**	**9%**	92	11%	88	11%
Total Orders made or revoked	**925**	**100%**	807	100%	823	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 **

	2020–21	2019–20	2018–19
Treatment was able to be provided in a less restrictive manner	**72%**	68%	59%
Treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person	**13%**	14%	19%
Immediate treatment was not able to be provided	**3%**	6%	10%
The person did not have a mental illness	**12%**	12%	12%
Total	**100%**	100%	100%

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

Variation hearings

The Tribunal must initiate a variation hearing when an authorised psychiatrist varies a Community Treatment Order to an Inpatient Treatment Order. The hearing must occur within 28 days of the variation and the Tribunal must determine whether to make a Treatment Order or revoke the Inpatient Treatment Order.

Table 10: *Outcomes of variation hearings*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Community Treatment Orders made	**100**	**16%**	78	12%	105	16%
Inpatient Treatment Orders made	**483**	**77%**	522	80%	501	76%
Treatment Orders revoked	**46**	**7%**	56	8%	56	8%
Total Treatment Orders made or revoked	**629**	**100%**	656	100%	662	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 **

	2020–21	2019–20	2018–19
Treatment was able to be provided in a less restrictive manner	**20%**	12%	23%
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	**2%**	3%	5%
Immediate treatment was not able to be provided	**78%**	85%	67%
The person did not have a mental illness	**0%**	0%	5%
Total	**100%**	100%	100%

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

2.2 ECT Orders – Adults

2.2.1 Outcomes of applications for an ECT Order

In 2020-21 the Tribunal heard a total of 612 applications for an electroconvulsive treatment (ECT) Order. Four hundred and eighty-two ECT Orders were made for adult compulsory patients and 77 applications were refused. Fifty ECT Orders were made in relation to adults being treated as voluntary patients and three applications were refused.

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

	2020–21	2019–20	2018–19
	No.	No.	No.
Compulsory adult patient			
ECT Orders made	**482**	477	539
ECT applications refused	**77**	74	98
Voluntary adult patient			
ECT Orders made	**50**	55	43
ECT applications refused	**3**	4	0
ECT Orders made and applications refused	**612**	610	680

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*

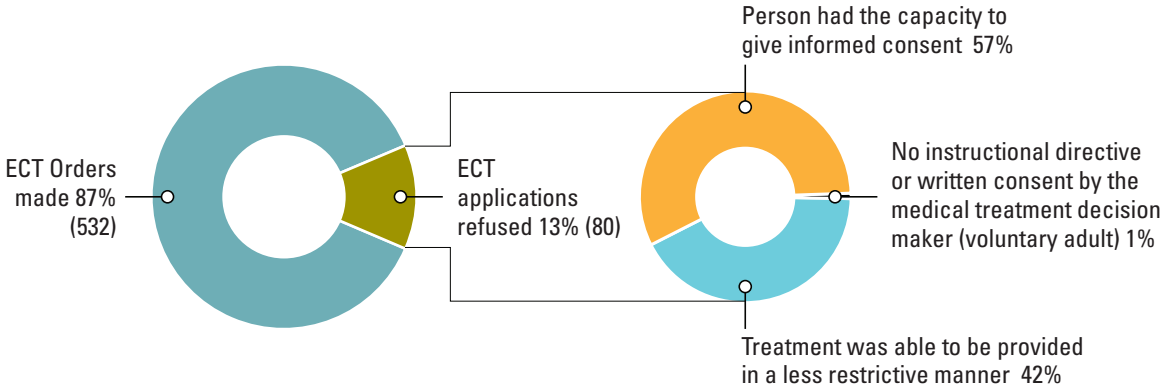


Table 13: *Determinations regarding ECT applications*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
ECT Orders made	**532**	**87%**	532	87%	582	86%
ECT applications refused	**80**	**13%**	78	13%	98	14%
Total ECT Orders made or applications refused	**612**	**100%**	610^	100%	680*	100%

** 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 **

	2020–21	2019–20	2018–19
Treatment was able to be provided in a less restrictive manner	**42%**	45%	61%
Patient had the capacity to give informed consent	**57%**	55%	39%
No instructional directive or written consent by the medical treatment decision maker (voluntary adult)	**1%**	0%	0%
Total	**100%**	100%	100%

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

Figure 5: *Duration of ECT Orders*

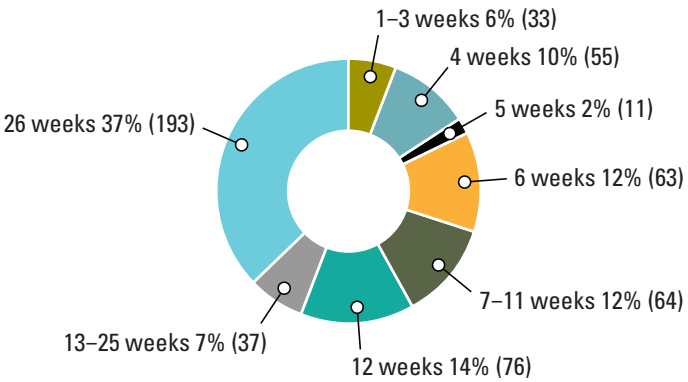


Table 15: *Duration of ECT Orders*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
1–3 weeks	**33**	**6%**	44	8%	53	9%
4 weeks	**55**	**10%**	50	9%	66	11%
5 weeks	**11**	**2%**	14	3%	4	1%
6 weeks	**63**	**12%**	54	10%	57	10%
7–11 weeks	**64**	**12%**	56	11%	50	9%
12 weeks	**76**	**14%**	70	13%	71	12%
13–25 weeks	**37**	**7%**	32	6%	72	12%
26 weeks	**193**	**37%**	212	40%	209	36%
Total	**532**	**100%**	532	100%	582	100%

Figure 6: *Number of ECT treatments authorised*

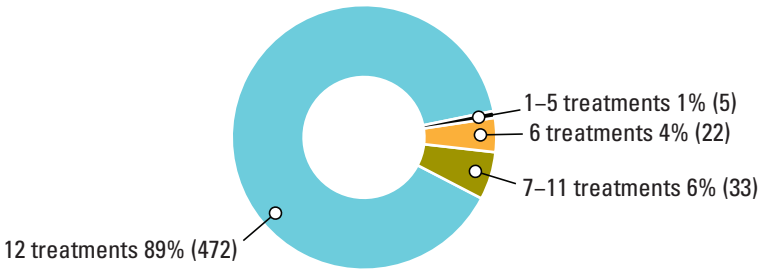


Table 16: *Number of ECT treatments authorised*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
1–5 treatments	**5**	**1%**	7	1%	11	2%
6 treatments	**22**	**4%**	21	4%	34	6%
7–11 treatments	**33**	**6%**	32	6%	54	9%
12 treatments	**472**	**89%**	472	89%	483	83%
Total	**532**	**100%**	532	100%	582	100%

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

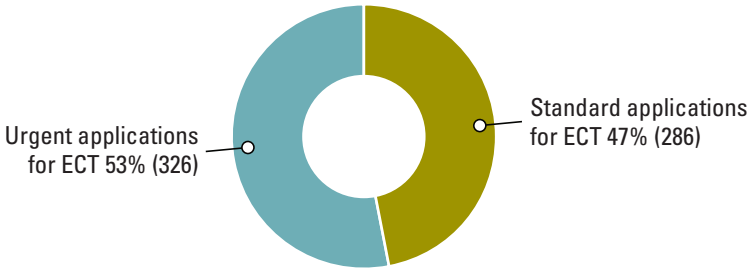


Table 17: *Proportion of applications for ECT Orders that were urgent*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Urgent applications for ECT	**326**	**53%**	301	49%	360	53%
Standard applications for ECT	**286**	**47%**	309	51%	320	47%
Total ECT applications	**612**	**100%**	610	100%	680	100%

2.2.2 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 2020-21, 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*

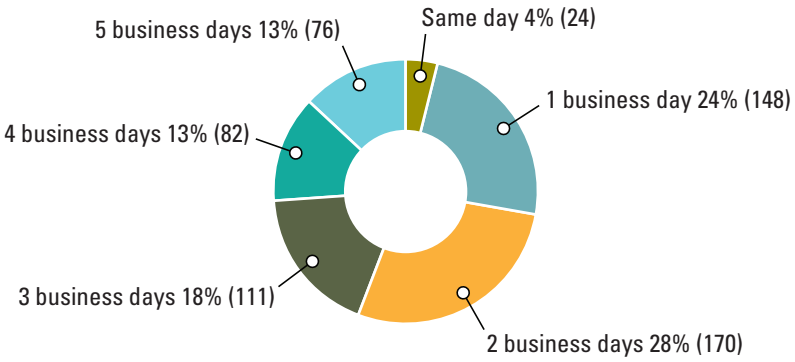


Table 18: *Elapsed time from receipt of ECT applications to hearing*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Same day	**24**	**4%**	41	7%	52	8%
1 business day	**148**	**24%**	128	21%	145	21%
2 business days	**170**	**28%**	152	25%	196	29%
3 business days	**111**	**18%**	131	21%	136	20%
4 business days	**82**	**13%**	102	17%	105	16%
5 business days	**76**	**13%**	56	9%	43	6%
Total	**611**	**100%**	610	100%	677	100%

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

Compulsory patients

During 2020-21, five 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 2020-21, the Tribunal received three 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*

	2020–21	2019–20	2018–19
	No.	No.	No.
Compulsory patients – ECT Orders made			
Patient's age: 14	**0**	0	1
Patient's age: 15	**1**	0	0
Patient's age: 16	**2**	1	0
Patient's age: 17	**2**	2	2
Voluntary patients - ECT Orders made			
Patient's age: 14	**0**	1	2
Patient's age: 15	**0**	2	2
Patient's age: 16	**1**	1	0
Patient's age: 17	**1**	0	3
Total	**7**	7	10

2.4 Neurosurgery for mental illness

During 2020-21, the Tribunal received three 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	St Vincent's Hospital NMI 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	NSW	Granted

2.5 Security patients

During 2020-21, the Tribunal made 128 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*

	2020–21	2019–20	2018–19
	No.	No.	No.
Hearings for a security patient			
28 day review			
Remain a security patient	**110**	88	75
Discharge as a security patient	**5**	3	1
Six month review			
Remain a security patient	**10**	5	5
Discharge as a security patient	**0**	0	0
Application for revocation by or on behalf of the patient			
Remain a security patient	**2**	2	5
Applications struck out	**1**	1	0
Total	**128**	99	86
Application by a security patient regarding leave			
Applications granted	**0**	0	0
Applications refused	**0**	0	0
Total	**0**	0	0

2.6 Applications to review the transfer of patient to another service

During 2020-21, the Tribunal received four 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*

	2020–21	2019–20	2018–19
Applications granted	**1**	0	4
Applications refused	**3**	5	3
Applications struck out	**0**	0	0
No jurisdiction	**0**	1	1
Total	**4**	6	8

2.7 Applications to transfer a patient interstate

During 2020-21 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*

	2020–21	2019–20	2018–19
Applications granted	**0**	0	2
Applications refused	**0**	0	0
Applications struck out	**0**	0	0
No jurisdiction	**0**	0	0
Total	**0**	0	2

2.8 Applications to deny access to documents

During 2020-21, the Tribunal received 115 applications to deny access to documents.

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

	2020–21	2019–20	2018–19
Applications granted	**99**	128	55
Applications refused	**10**	31	9
Applications struck out	**6**	5	3
No jurisdiction	**0**	1	0
Total	**115**	165	67

2.9 Applications for review by VCAT

During 2020-21, 26 applications were made to VCAT for a review of a Tribunal decision.

Table 25: *Applications to VCAT and their status*

	2020–21	2019–20	2018–19
Applications made	**26**	31	27
Applications withdrawn	**9**	13	11
Applications struck out	**0**	2*	0
Applications dismissed	**3**	5	0
Hearings vacated	**2**	2	3
Decision set aside by consent	**0**	0	0
No jurisdiction	**0**	0	2
Applications proceeded to full hearing and determination	**10**	13	10
Applications pending at 30 June	**4**	2*	4

** The data reported in the 2019-20 Annual Report contained an error. One of the applications that was recorded as pending at 30 June 2020 should have been recorded as struck out. The data in the 2019-20 column has been corrected.*

Table 26: *Outcomes of applications determined by VCAT*

	2020–21	2019–20	2018–19
Decisions affirmed	**9**	12	8
Decisions varied	**1**	0	1
Decision set aside and another decision made in substitution	**0**	1	0
Orders revoked	**0**	0	1

2.10 Adjournments

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

The Tribunal cannot adjourn a hearing to a date that is after the date on which a patient's current Treatment Order expires unless the Tribunal is satisfied that exceptional circumstances exist. If exceptional circumstances do exist, the Tribunal may extend the duration of the patient's Temporary Treatment Order or Treatment Order, but only for a maximum of ten business days, and the Tribunal must not extend the Order more than once.

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

Figure 9: *Hearings adjourned*

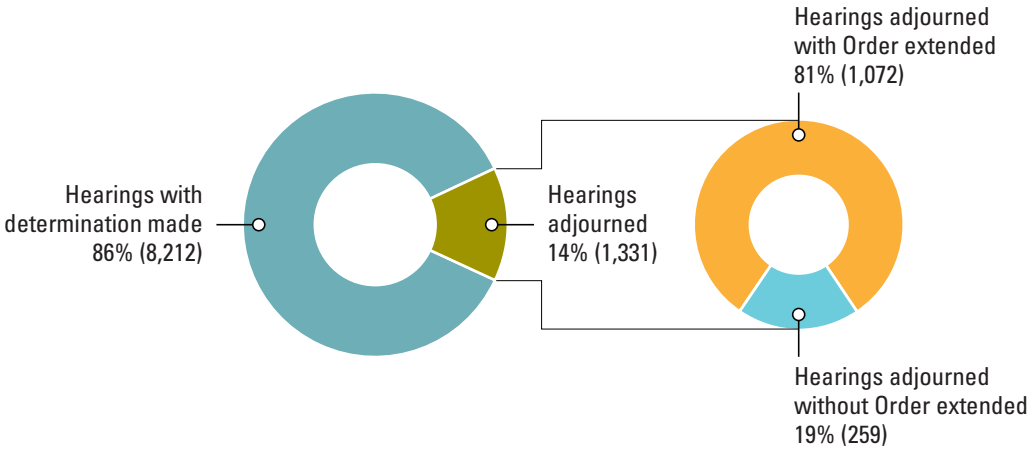


Table 27: *Hearings adjourned*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Hearings adjourned without Order extended	**259**	**19%**	211	21%	172	19%
Hearings adjourned with Order extended	**1,072**	**81%**	814	79%	712	81%
Total	**1,331**	**100%**	1,025	100%	884	100%
Hearings adjourned as a percentage of total hearings conducted	**14%**		12%		10%	

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

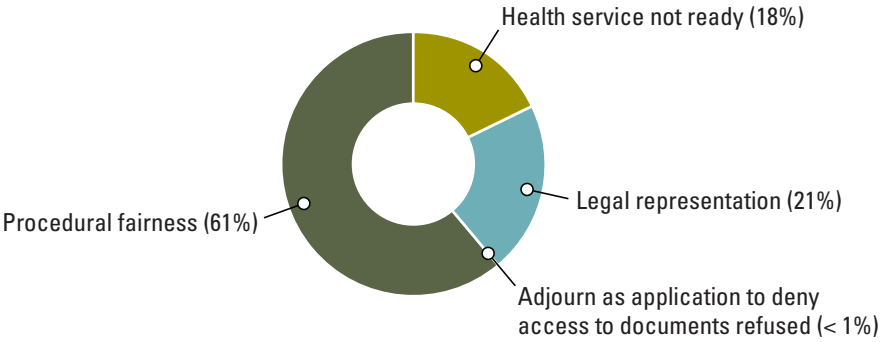


Table 28: *Reasons for adjournments with extension of Order*

	2020–21	2019–20	2018–19
Procedural fairness – patient participation or other support *	**38%**	42%	–*
Procedural fairness – enable access to report / file *	**16%**	11%	–*
Procedural fairness (other)	**7%**	6%	60%
Health service not ready – report not prepared *	**5%**	6%	–*
Health service not ready – transfer *	**1%**	5%	–*
Health service not ready – treating team attendance *	**10%**	7%	–*
Health service not ready (other)	**2%**	2%	20%
Legal representation	**21%**	20%	20%
Unable to constitute three-member division *	**0%**	1%	–*
Adjourn as application to deny access to documents refused	**< 1%**	0%	0%
Total	**100%**	100%	100%

** Additional reasons for adjournment with extension of Order were added on 1 July 2019 and direct comparisons with 2018-19 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*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Patient	**5,956**	**63%**	5,042	59%	4,826	56%
Family member	**1,713**	**18%**	1,544	18%	1,522	18%
Carer	**373**	**4%**	372	4%	440	5%
Nominated person	**250**	**3%**	195	2%	246	3%
Medical treatment decision maker	**25**	**< 1%**	37	< 1%	31	< 1%
Support person	**2**	**< 1%**	0	0%	0	0%
Interpreter	**455**	**5%**	433	5%	364	4%
Legal representative	**1,255**	**13%**	1,157	13%	1,162	13%

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 2020-21.

Table 30: *Legal representation at hearings*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
Victoria Legal Aid	**1,078**	**12%**	1,009	12%	1,003	12%
Mental Health Legal Centre	**128**	**1%**	103	1%	123	1%
Private Lawyer	**31**	**< 1%**	31	< 1%	28	< 1%
Other Community Legal Centre	**18**	**< 1%**	14	< 1%	8	< 1%
Total legal representation	**1,255**	**13%**	1,157	13%	1,162	13%

2.12 Mode of conducting hearings

In 2020-21, all hearings were conducted by telephone.

Table 31: *Hearings conducted by mode*

	2020–21		2019–20		2018–19	
	No.	**%**	No.	%	No.	%
In-person	**0**	**0%**	5,213	59%	6,627	77%
Video conference*	**N/A**	**N/A**	1,425	16%	1,978	23%
Teleconference	**9,543**	**100%**	2,148	25%	34	0%
Totals hearings conducted	**9,543**	**100%**	8,786	100%	8,639	100%

** Complete data about the number of hearings conducted with ancillary video in 2020-21 is not available.*

2.13 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 32: *Hearings not conducted within statutory deadlines*

Not conducted within statutory deadlines	**Count**
Hearing unable to proceed because the patient's Treatment Order had expired #	1
Hearing adjourned by the Tribunal to be heard out of time *	35
Hearing conducted out of time ^	4
Total	40

 # One hearing could not proceed due to an error on the part of the Tribunal.

** 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; all four arose because of an error on the part of a health service.

2.14 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 2020-21, the Tribunal responded to 78% 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 2020-21, the Tribunal achieved this target 99% of the time.

Table 33: *Sending Treatment and ECT Orders to relevant parties*

	2020–21	2019–20	2018–19
Percentage of Orders sent to parties within five working days of a hearing	**99%**	64%	57%
Average number of days to send Orders to parties	**Same day**	6 days	6 days

PART 3 | EMBEDDING THE MENTAL HEALTH PRINCIPLES IN THE TRIBUNAL'S WORK AND ENGAGEMENT

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

…

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

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

The Act sets down 12 mental health principles to guide the provision of mental health services. As the Victorian Supreme Court confirmed in its landmark decision in *PBU & NJE v Mental Health Tribunal*, persons performing duties or functions or exercising powers under the Act, including the Tribunal, must have regard to these principles. The principles focus on least restrictive treatment and promote recovery and full participation in community life. Among other things, they emphasise that consumers should be involved in all decisions about their treatment and recovery and supported to make, or participate in, decisions. The principles state that the rights, dignity and autonomy of persons receiving mental health services should be respected and promoted.

The Tribunal's commitment to upholding these principles in our hearing and administrative functions is reflected in our vision, which is that the principles and objectives of the *Mental Health Act 2014* are reflected in the experience of consumers and carers. Flowing from our vision, the strategic priorities set out in our Strategic Plan for 2018-2020 (which, given the impact of the pandemic, the Tribunal decided to extend to 2021) 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 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.

The case studies of recent hearings included in this section have a particular focus on how the Tribunal supports consumers to participate in the hearing and express their views and preferences about their treatment and recovery. They also illustrate how the Tribunal considers consumers' views and preferences in its decisions.

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:

1. Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.
2. 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.
3. 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.
4. Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
5. Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.
6. Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
7. 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.
8. Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.
9. 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.
10. Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.
11. Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
12. 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

CASE STUDY

HOW THE TRIBUNAL DETERMINES WHETHER THERE IS NO LESS RESTRICTIVE WAY FOR THE PERSON TO BE TREATED IN ECT HEARINGS

The second criterion the Tribunal must consider when deciding whether to make an Order allowing a person to be treated with electroconvulsive treatment (ECT) is whether there is no less restrictive way for the person to be treated. The Supreme Court decision of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (PBU & NJE) confirmed that the legal test is not whether ECT is in the patient's best interests; instead, the Tribunal must have regard to both subjective and objective considerations including the patient's views and preferences in relation to ECT and any beneficial alternative treatments and the reasons for those views and preferences, including any recovery outcomes the patient wants to achieve.

In EHI [2020] VMHT 22, the patient had been receiving medications and compulsory maintenance ECT during his hospital admission. EHI's preference was to increase the dose of his medications rather than have more ECT and his lawyer submitted this was a viable less restrictive alternative to ECT. But EHI's treating team said he needed the combination of medications and maintenance ECT, and they were concerned that an increase in the dose of EHI's medications may cause side effects that he would not get from ECT.

In making its decision, the Tribunal accepted that the level of distress ECT caused to EHI, including his concerns about the mental and social side effects, was a relevant consideration even though EHI had not experienced medical side effects from previous rounds of ECT. The Tribunal weighed these factors against the consequences EHI might experience if he did not receive ECT. The treating team said EHI's mental state may worsen and he may experience side effects from increasing the dose of his medications. However, the Tribunal noted EHI had not experienced side effects from his current medication. This was an indicator that he may not experience side effects from an increased dose. The Tribunal therefore decided there was a less restrictive way to treat EHI and refused the ECT application.

In BHI [2020] VMHT 19, BHI's treating team said BHI was still manic and ECT was less restrictive than continuing with medication alone because it would deliver a quicker response and relief of BHI's symptoms. But BHI's clear preference was not to have ECT. He preferred a longer hospital admission to trial different medications and dosages than having ECT.

Consistent with PBU & NJE, the Tribunal said the test is not what is in the patient's best interests. In this case, the Tribunal could not be satisfied that ECT would necessarily deliver a quicker response because BHI had never received ECT. The Tribunal gave considerable weight to the fact that BHI's clear preference was not to have ECT. It also considered the consequences if BHI did not receive ECT – he would likely spend more time in hospital, but BHI was aware of this and still preferred this over ECT. The Tribunal therefore decided there was a less restrictive treatment option and refused the ECT application.

In LDH [2021] VMHT 14, the Tribunal was deciding a second application for an ECT Order. A different division of the Tribunal had refused the first application. In such a case, the Tribunal isn't reviewing the earlier decision but hearing the matter 'afresh' and making a decision based on the circumstances at the time of the second hearing.

LDH had been an inpatient for some time and did not want ECT. He thought being in hospital was a waste of time and he wanted to leave hospital to support his partner. LDH also had a medical condition that he wanted addressed. He did not believe there was a connection between addressing his mental health symptoms and working with the medical team to develop and implement a treatment plan for his other medical condition. LDH's mental health treating team gave evidence that the medical team had decided it was unable to work with LDH until his mental state was more settled.

LDH's treating team said his thinking was dominated by delusions and his mood had remained elevated throughout his admission. In the time since the first hearing, LDH had remained in hospital but continued to refuse any mood stabilising medications even though his mood symptoms were persisting and not resolving. LDH was also exhibiting signs of a cardiac condition that meant his antipsychotic medication may need to be reduced, even though his symptoms persisted.

In relation to his capacity to give informed consent to ECT, the Tribunal decided LDH was unable to use or weigh information relevant to the decision. In deciding whether there was a less restrictive way to treat LDH, the Tribunal gave considerable weight to LDH's preference not to have ECT. His previous experience of ECT was distressing and he said it dulled his mind and made him feel numb. Against this, the Tribunal had to consider the medical evidence. LDH continued to refuse any mood stabilising medication so his symptoms were persisting, but the medication options were increasingly complicated. In this case, the Tribunal considered there appeared to be no real alternative treatment available to LDH.

The Tribunal also had regard to LDH's recovery goals, which included returning home to support his partner and commencing treatment for his other medical condition. While LDH said he preferred staying in hospital rather than having ECT, the Tribunal was satisfied that remaining in hospital but refusing mood-stabilising medication would prolong an already long hospital admission and would delay LDH achieving his broader goals. On balance, the Tribunal decided there was no less restrictive way for LDH to be treated and made an ECT Order approving up to 12 treatments over eight weeks.

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 and lived experience workforce members, along with the Deputy President, Chief Executive Officer and Consumer & Carer Engagement Officer of the Tribunal. 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 2020-21, the TAG farewelled two members, William Lau and Judith Drake. We thank both members for their contribution to the work of the TAG. The Tribunal welcomes two new members, Natasha Gore and Elvis Martin, and we look forward to continuing to learn from the expertise our current and newest members bring to the work of the TAG.

One of the TAG's major activities this year has been to oversee the finalisation of the Tribunal's response to the 10-point Action Plan to increase attendance and participation at hearings (see next section). In addition, the TAG has provided advice on:

- teleconference hearings
- our new treatment report template
- our next strategic plan
- video-conference platform requirements.

3.1.2 Action plan to increase attendance and participation at hearings

Two of the Tribunal's key strategic priorities are ensuring fair, consistent and solution-focused hearings and promoting the realisation of the principles and objectives of the Act.

These priorities are reflected in our work on increasing attendance and participation in hearings, which commenced in 2019 when, as part of our 2019 Consumer and Carer Forum, we conducted a workshop to explore what the Tribunal could do to encourage higher rates of attendance. The outcome of that workshop was the development of an Action Plan. We have since implemented the Action Plan in full, as described on the following page.

Overall, the rate of patient attendance at hearings has increased from 56% to 63% since December 2019. While it is difficult to attribute this to any single action, one factor is very clear – attendance jumped when the pandemic required the Tribunal to switch to conducting hearings by teleconference. The Tribunal does not view this as a reason to persist with teleconference hearings any longer than we have to; rather, we believe it demonstrates that consumers want options for how they attend and participate in hearings. Accordingly, we are looking at how we can build flexibility into our future processes.

Implementation of our Action Plan to increase attendance and participation at hearings

What we committed to	What we achieved and when
Action 1: Work with health services to improve hearing notifications	**2019-ongoing:** We continued to encourage health services to collect up to date contact details from consumers and carers to ensure we can notify them of hearings. Where contact information is found to be incorrect, the treating health service is advised of this.
Action 2: Notify and remind patients of hearings by text messages and email	**2021:** We successfully trialled notifying and reminding patients of hearings by text message. We now send text messages as standard practice. The text messages are sent in addition to letters notifying consumers of hearings. On the advice of the TAG, we decided not to email notifications of hearings as well as sending the letter and text message notifications.
Action 3: Tell patients how to request a change of hearing date	**2019:** We changed our letters notifying patients of hearings to let them know that they can request a different hearing date.
Action 4: Stick to hearing times	**2020 – ongoing:** The Tribunal took over setting hearing times from the health services when we transitioned to conducting hearings by telephone. This improved our performance in conducting hearings on time. We will continue to look for ways to ensure there is enough time scheduled for each hearing to meet individual needs and ensure hearings run on time.
Action 5: Recovery focused report templates	**2020 – ongoing:** We designed and implemented new report templates for hearings about Treatment Orders, Secure Treatment Orders and Court Secure Treatment Orders. Review of these templates and the development of additional recovery-focused report templates is continuing.
Action 6: Tell patients we will listen to them	**2019:** We designed and trialled new letters notifying patients of hearings that tell them that we want to hear from them. We have now adopted these as our standard forms.
Action 7: Health service support for patients to participate in hearings	**2020 – ongoing:** We engaged with health services about how to support patients to participate in hearings, including through training we provided about writing reports and providing documents for Tribunal hearings.
Action 8: More guidance for carers on participation in hearings	**2020:** We produced a video providing family members, friends and carers with guidance on how they can effectively participate in Tribunal hearings. This is available on our website.
Action 9: Tell patients who is attending the hearing	**2019:** We added a line to our notice of hearing letters that lets patients know which of their family members, carers or nominated persons have also been notified of the hearing.
Action 10: Further promote interpreters and information in other languages	**2019 – continuing:** We encourage health services to identify consumers and carers needing interpreters so arrangements can be confirmed well in advance of hearings. **2019:** We had information about the Tribunal translated into 16 languages, made it available on our website and encouraged health services to provide it to consumers.

CASE STUDY

APPLICATION FOR REVIEW OF A DIRECTION TO VARY AN ORDER

Section 65 of the *Mental Health Act 2014* (the Act) allows an authorised psychiatrist to vary certain Orders, including Treatment Orders, to specify that the assessment or treatment of the patient be provided by another designated mental health service. The chief psychiatrist also has the power to direct the variation of an Order. If the person does not agree with the variation, under section 66 of the Act they can apply to the Tribunal for a review of the decision to vary the Order. The Tribunal's power is only enlivened if the person applies to the Tribunal to review the decision to vary the Order. This means the transfer can proceed if the person agrees to the transfer.

The Tribunal exercises a review function when conducting hearings under section 66 of the Act. The statutory test is set out in section 65(2) of the Act. There are two limbs to the test – first, the Tribunal must be satisfied the variation is necessary for the person's assessment or treatment, and second, the Tribunal must be satisfied the authorised psychiatrist at the new designated mental health service has approved the variation.

In LJV [2020] VMHT 33, the patient had been an inpatient for several months. LJV's psychiatrist wanted LJV to receive long-term rehabilitation treatment so they varied his Treatment Order to specify that he receive treatment from a Secure Extended Care Unit (SECU) operated by another designated mental health service. LJV applied to the Tribunal for a review of the decision to vary his Treatment Order.

LJV's long term goal was to live independently in the community. But LJV did not want to receive treatment at the rehabilitation unit – he viewed this as a step backwards in his recovery. He had previously received treatment at a SECU and he did not want to go back there. LJV said he had a good relationship with the nursing staff and felt he could work with his doctors at the hospital. His preference was to remain in hospital until a bed became available in a Supported Rehabilitation Service.

The treating team said LJV's clozapine dose needed to be increased and this could take several months. The treating team thought LJV would benefit from receiving treatment at the SECU that focused on rehabilitation and recovery. However, LJV's psychiatrist was unable to provide specific information about why the transfer was necessary for LJV's treatment or assessment.

LJV's lawyer submitted the transfer must be necessary, not what's optimal, and the Tribunal required clear information about the treatment that was available at the SECU. He said the transfer was not necessary and LJV's medication dose could be increased in hospital.

The Tribunal considered LJV's views and preferences about the transfer. His aim was to live more independently in the community, but he was clear in stating his previous experience at SECU was negative, and he liked the hospital and had made connections there.

In determining whether the treatment was necessary for LJV's treatment, the Tribunal considered whether the treatment available at the rehabilitation unit was sufficiently important to justify overriding LJV's views and preferences. However, the treating team was unable to provide specific details of the assessment or treatment that LJV would flow from the transfer. In the absence of this information, the Tribunal could not be satisfied the transfer was necessary. This meant the Tribunal granted LJV's application and he would continue to receive treatment in hospital.

Even though LJV applied for a review of the decision to transfer his treatment, at the end of the hearing LJV's lawyer said LJV would benefit from more information about the proposed transfer and acknowledged that as a result of the discussions during the hearing, LJV appeared less opposed to the transfer. This decision highlights that by facilitating a solution focused discussion between the Tribunal, the patient and their treating team, options for what is to happen next can emerge. While the Tribunal granted the application against the transfer, it noted that this did not prevent further exploration of which service was most appropriate to treat LJV.

3.2 Publication of the second edition of the *Guide to Solution-focused hearings in the Mental Health Tribunal*

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.

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 continuing to develop and improve our understanding of solution-focused hearings. This year, the Tribunal published the second edition of our *Guide to solution-focused hearings in the Mental Health Tribunal*, which is now available under the guides, policies and procedures tab on our website.

This completely revised edition includes chapters that were completed since the guide was first published in 2014. These explore the specific needs of younger and older consumers and how to most effectively promote the participation of carers and the broad range of support people involved in hearings. A constant theme throughout this new edition is the link between a solution-focused approach and the mental health principles.

This edition of the guide also includes case studies based on real hearings, while new sections explore how a solution-focused approach can assist in handling some of the most complex issues that arise in hearings. The work of speech pathologist, criminologist and courage facilitator, Rosalie Martin, informs the second edition as does the Recovery Oriented Language Guide of the New South Wales Mental Health Co-ordinating Council, which is also included as an appendix.

3.3 Engagement with the Royal Commission into Victoria's Mental Health System

The Tribunal continued to engage with the Royal Commission in the second half of 2020. The Tribunal's President provided a witness statement in response to a number of specific questions and issues put by the Royal Commission. Following this, the President participated in the Royal Commission's panel hearing on compulsory treatment alongside Prof Lisa Brophy, Dr Chris Maylea and Prof Ruth Vine. The Royal Commission also convened a roundtable with a number of Tribunal members and staff. After reflecting on the issues covered across these interactions with the Royal Commission, the Tribunal provided a second submission that used both the mental health principles in the Mental Health Act and the reasonable limitations framework in the Charter of Human Rights and Responsibilities as points of reference to provide a number of potential reforms for the Royal Commission's consideration.

3.4 Tribunal Area Mental Health Service Working Group

The Tribunal has established a working group (TWG) to consult with Area Mental Health Services about key administrative practices that have been affected by the COVID-19 pandemic. The group includes representatives from each Area Mental Health Service, providing the Tribunal with a valuable opportunity to improve our engagement with these services and to work together to ensure consumers have the opportunity to participate in fair hearings despite the disruptions brought about by the pandemic. The meetings have been held once a month since August 2020.

The TWG has provided essential advice on a range of matters, including a process for health services to upload their hearing documents directly into the Tribunal's extranet so they can be accessed and reviewed securely by members in advance of hearings. The TWG has also advised on planning for a pilot of online video hearings. The TWG will continue its work throughout 2021-22.

CASE STUDY

CONSIDERATION OF THE MENTAL HEALTH PRINCIPLES IN DETERMINING WHETHER THE PERSON CAN BE TREATED LESS RESTRICTIVELY

In Treatment Order hearings, the last criterion the Tribunal must consider is whether 'there is no less restrictive means reasonably available to enable the person to receive the immediate treatment'. This criterion requires the Tribunal to consider whether the person needs to be compelled to receive treatment under a Treatment Order or whether they could receive treatment on a voluntary basis. The Tribunal must have regard to the mental health principles, including the principle that says, '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 referred to as the 'dignity of risk' principle. The following cases illustrate how the Tribunal has regard to the mental health principles, including the 'dignity of risk' principle when deciding whether the person can be treated less restrictively.

In KAL [2020] VMHT 41, KAL said he would stop the medication if he was not on a Treatment Order, but he would stay in contact with his case manager and his general practitioner. He would also continue to see his support worker with whom he had regular contact each week. KAL's treating team said he needed to be a compulsory patient because he would stop treatment if the decision was up to him. If he did not receive treatment, he would become more disorganised, less able to enjoy his lifestyle and he would experience a psychosocial decline.

KAL had been subject to compulsory treatment for a considerable time and it was particularly burdensome for him. The Tribunal accepted he was actively engaged in community life and a deterioration in his mental state may disrupt his quality of life. The Tribunal acknowledged there was some risk to KAL if he was not on a Treatment Order and stopped his medication, but he was well supported by a number of people in the community and this mitigated the risks to a significant extent.

The Tribunal acknowledged that even though KAL would not accept medication, 'treatment' was not limited to medication alone and KAL was accepting of other critical supports and contact from friends, support workers and some clinicians. The support and monitoring provided by that network was an important aspect of KAL's treatment. In balancing the mental health principles, KAL's preferences and the level of support he had around him, the Tribunal accepted KAL could receive treatment less restrictively and revoked KAL's Treatment Order.

In YDK [2020] VMHT 18, YDK's lawyer submitted he could be treated on a voluntary basis because he would continue to take the injectable (depot) medication. YDK viewed the depot medication as 'the lesser of two evils' and he preferred to receive that treatment in the community than go to hospital because he believed the treating team could perform psychosurgery on him while he was asleep in hospital. YDK acknowledged the medication 'takes the edge off things' and he was willing to continue to see his case manager in the community. He also had the support of an NDIS worker. However, YDK's treating team was concerned he would stop treatment if he was not on a Treatment Order and would disengage as had occurred in the past.

The Tribunal stated that YDK's past history of disengagement was not the only consideration in deciding whether he could receive voluntary treatment and the Tribunal could not presume this was YDK's fault. The Tribunal said it was not relevant whether YDK's beliefs about treatment were based in fact. His beliefs about treatment meant he was more resistant to compulsory treatment, but at the same time his beliefs meant there was a strong likelihood he would continue with treatment on a voluntary basis. The Tribunal therefore revoked YDK's Treatment Order and acknowledged there was a degree of risk in revoking the Order, but it was manageable because YDK would continue to see his case manager who could intervene if YDK's mental health deteriorated.

However, in AGD [2020] VMHT 20 the Tribunal's consideration of the dignity of risk principle favoured making a Treatment Order. In that case, AGD had been an inpatient for a considerable time following a serious relapse of her mental illness. Prior to her hospital admission, AGD had managed her mental illness on a voluntary basis for more than a decade. AGD agreed she needed treatment and was willing to continue with the current treatment, but she wanted to leave hospital. The treating team explained that electroconvulsive treatment (ECT) was a part of AGD's treatment; however, ECT was only available to inpatients because of the COVID-19 restrictions in place at that time. Accordingly, the treating team said AGD needed to receive treatment in hospital while she continued to recover.

The Tribunal considered AGD's history of voluntary treatment and her willingness to continue to receive treatment were protective factors that supported revoking the Order. However, these factors needed to be considered alongside what the treating team said about treatment. The Tribunal accepted the symptoms of AGD's relapse appeared to be impacting on her ability to understand the treating team's reasons for wanting her to remain in hospital. AGD had experienced a serious relapse of her illness and it had been difficult to relieve the symptoms of her illness. Even though AGD had received voluntary treatment for a number of years, the Tribunal decided the symptoms of her relapse meant the risks were too high for her be treated on a voluntary basis. The Tribunal therefore decided there was no less restrictive way for AGD to be treated and made a 16-week Inpatient Treatment Order.

CASE STUDY

EXAMINING HOW THE TRIBUNAL DECIDES THE SETTING AND DURATION OF TREATMENT ORDERS

If the Tribunal is satisfied the treatment criteria are met, it must decide whether the person will receive treatment in the community on a Community Treatment Order or in hospital on an Inpatient Treatment Order. The Act says the Tribunal can only make an Inpatient Treatment Order if it is satisfied treatment cannot occur in the community. The Tribunal must also set the duration of the Order. The Act does not specify the considerations the Tribunal must look at in determining the duration of the Order. Some of the factors the Tribunal may consider include the current and proposed treatment (including any planned changes to treatment), how long it is likely to take for the patient's mental health to stabilise with treatment and how long it is expected to take to transition to voluntary treatment, as well as the patient's psychiatric history. The following cases illustrate some of the considerations the Tribunal has regard to when deciding the duration and setting of the Treatment Order.

In DNP [2020] VMHT 42, the patient had managed her mental health on a voluntary basis for more than a decade. DNP had experienced a relapse of her illness that resulted in a compulsory hospital admission; however, her mental health had improved during her admission such that her discharge from hospital was planned for the day before the hearing. However, that plan changed because DNP's private psychiatrist was unable to take on her care at that time. The treating team said the new plan was for DNP to meet with a case manager before being discharged from hospital shortly after the hearing.

DNP said the stalled discharge plan was especially upsetting and she wanted to go home. DNP was supported by her husband, who agreed she could be discharged from hospital. He said he and other family members would support DNP to attend appointments in the community.

The Tribunal weighed the risk of DNP leaving hospital immediately against the risk of her remaining in hospital. In DNP's case, the Tribunal considered the level of distress that remaining in hospital would cause to her and the impediment it could create to building trust and rapport with the community treating team favoured making a Community Treatment Order.

In determining the duration of the Order, the Tribunal considered that DNP had an extensive history of managing her mental illness on a voluntary basis and had the ongoing support of her family. The Tribunal accepted DNP only needed a short period of compulsory treatment to finalise her ongoing treatment plan. The Tribunal therefore made a 12-week Community Treatment Order.

In QGG [2021] VMHT 9, QGG was admitted to hospital after experiencing delusions about things at her home. She believed people were in her roof, thought someone was interfering with her phone and believed her identity had been stolen. The treating team acknowledged QGG agreed to have medication by a monthly injection in the future and she could have been discharged from hospital if her mental health issues were the only concern. However, a recent assessment by an occupational therapist showed QGG had experienced a functional decline and she needed more support to live at home. QGG needed to engage in further testing in the week after the hearing before she could be discharged from hospital. In addition, the electricity needed to be reconnected at QGG's home before she could be discharged.

In this case, the Tribunal decided to make an Inpatient Treatment Order because it was satisfied QGG needed to remain in hospital while her discharge and support plan was finalised. QGG had not had any leave during her stay in hospital and it was unclear whether going home would cause her symptoms to recur.

However, in deciding the duration of the Order, the Tribunal said QGG only needed a short period of compulsory treatment to ensure she remained in hospital while her discharge and support plan was finalised. She was otherwise agreeable to the recommended treatment and would accept the monthly injection in the future. The Tribunal therefore made a short four-week Inpatient Treatment Order.

3.5 New Treatment Report template

The patient report is an important communication tool. It informs patients about the views of the treating team. A patient hearing report assists the patient to prepare for and understand the issues to be discussed at a Tribunal hearing. It is considered best practice for hearing reports to include the perspectives of the patient.

In the Tribunal Hearing Experience (THE) survey conducted in 2019, feedback from patients and carers described the alienating experience of reading Compulsory Treatment Reports that contained inaccurate information, traversed historical and distressing events and did not reflect the concerns of carers. The THE survey results indicated that the Compulsory Treatment Report did not reflect discussions people had with their treating team or information about how they would like to be supported to achieve their recovery goals.

The Tribunal also received feedback from mental health services that they found completing the Compulsory Treatment Report template burdensome and the reports did not contribute to their work of providing treatment and care to patients. It was clear that Compulsory Treatment Reports were not assisting the Tribunal to provide positive hearing experiences for consumers, carers or health services.

In response to this feedback, the Tribunal commenced an initiative to encourage and support mental health services to write reports for hearings that better reflect the objects and principles of the Act and align with the Tribunal's value of delivering high quality, fair and patient-focused hearings. We consulted consumer and carer peak bodies, mental health services, the Office of the Chief Psychiatrist and Victoria Legal Aid during the development and roll-out of the initiative.

The new patient report template was released at the end of January 2021, together with guidance and online training information. Mental health services were asked to adopt and implement the new report template by March 2021.

The new patient report is designed to be written as a narrative with clear, short sentences. It is recommended that the report be addressed to the patient and written like a letter. The patient report template contains headings that reflect the criteria in the Act. The template discourages the use of medical jargon or acronyms. It recommends the use of recovery-focused language that highlights a patient's key strengths, periods of stability including engagement with voluntary treatment, strong relationships in their life and supports they would like to help them recover. The patient report template also contains prompts to encourage treating teams to focus on why voluntary treatment is not possible and why the proposed treatment is the least restrictive option.

It is expected that, as treating teams develop their skills at preparing reports written in this manner, these new reports will help all participants in hearings to engage in supported decision-making and promote least restrictive treatment and recovery-oriented practices, all of which are key themes in the principles of the Act.

Removing a patient's diagnosis from reports and the statistics collected by the Tribunal

When making a decision about Treatment Orders, the Tribunal must decide whether a person has a significant disturbance of thought, mood, perception or memory. It does not have to decide on or be satisfied about a particular diagnosis. The patient report template deliberately excludes a specific question about a patient's diagnosis. In the Tribunal's experience, a diagnostic label is often a source of contention between patients and treating teams and focusing on it can discourage attendance at and engagement in hearings. Where a diagnosis is a constructive element of the discussions that are occurring between a patient and their treating team, it can always be included as part of the report – the difference is that it's no longer required. Following on from this, the Tribunal has stopped recording data concerning diagnoses and this information is no longer included in Part 2 of our Annual Report.

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 in its annual report.

Funding sources and expenditure
The Tribunal receives a government appropriation directly from the Department of Health.

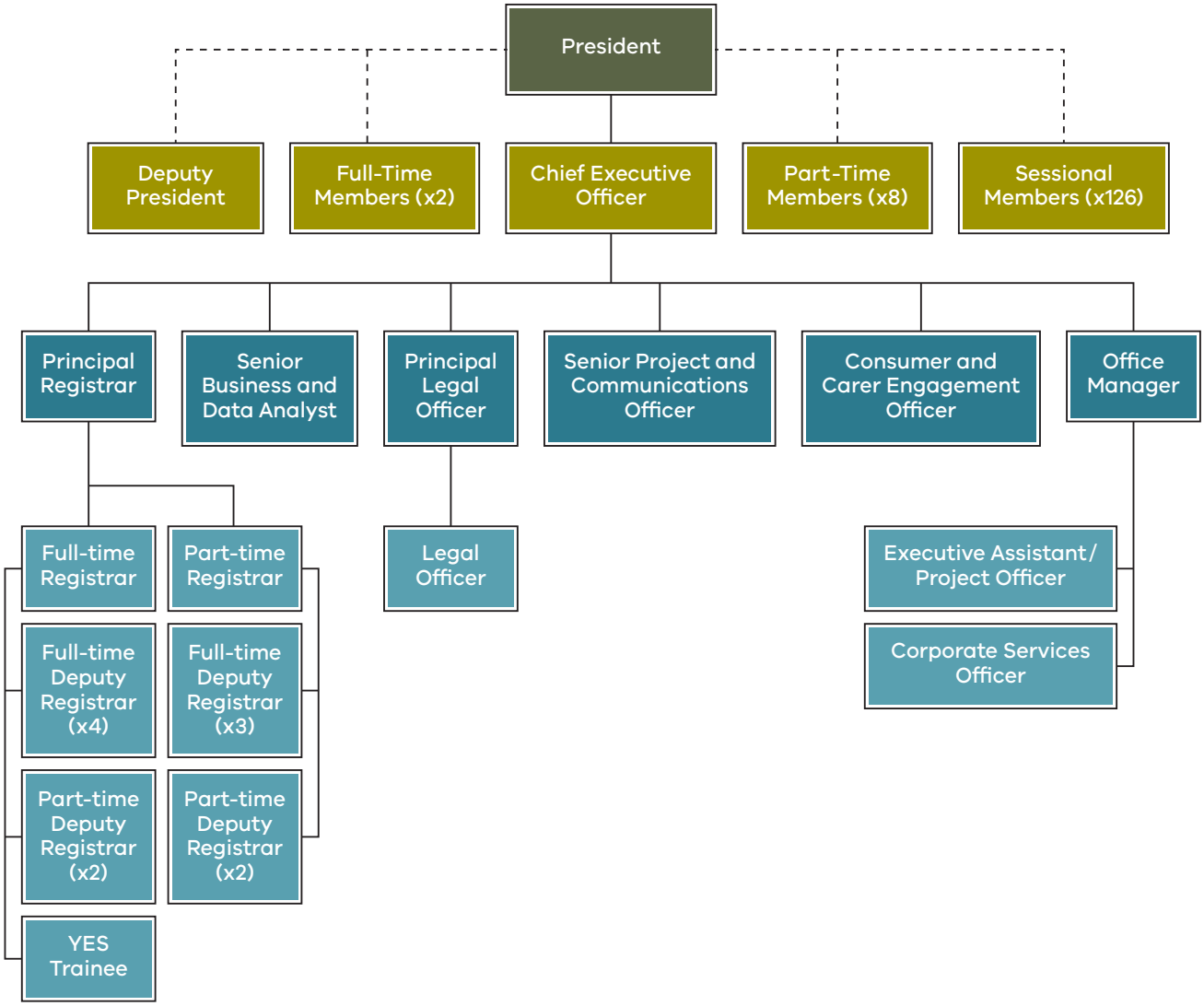
APPROPRIATION

	2020-21	2019-20	2018-19
TOTAL	**$10,331,839**	$10,372,077	$9,877,592

EXPENDITURE

Full and part-time member salaries	**$1,875,462**	$1,640,080	$1,693,225
Sessional member salaries	**$4,202,829**	$4,523,247	$4,315,542
Staff Salaries (includes contractors)	**$2,415,542**	$1,956,181	$1,821,447
Total Salaries	**$8,493,833**	$8,119,508	$7,830,214
Salary On costs	**$1,526,654**	$1,259,696	$1,256,896
Operating Expenses	**$583,100**	$770,794	$712,722
TOTAL	**$10,603,587**	$10,149,998	$9,799,832
Balance	**-$271,748**	$222,079	$77,760

Appendix B
Organisational Chart as at 30 June 2021



Appendix C
Membership List as at 30 June 2021

The composition of the Tribunal includes 80 female and 58 male members, made up of four full-time members (the President, Deputy President and two Senior Legal Members), eight part-time members and 126 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 – 1 Sept 2025 *(Appointed Senior Legal Member 15 March 2017)*

PART-TIME MEMBERS	Period of Appointment
Legal Members	
Mr Robert Daly	10 June 2013 – 9 June 2023 *(Appointed Part Time Legal Member 15 September 2020)*
Mr Brook Hely	25 Feb 2011 – 1 Sept 2025 *(Transitioned to sessional membership 15 September 2020)*
Ms Kim Magnussen	25 Feb 2011 – 1 Sept 2025
Psychiatrist Members	
Dr Sue Carey	25 Feb 2011 – 1 Sept 2025
Dr Michael McCausland	10 June 2018 – 9 June 2023 *(Appointed Part Time Psychiatrist Member 15 September 2020)*
Community Members	
Mr Ashley Dickinson	25 Feb 2011 – 1 Sept 2025
Dr Diane Sisely	25 Feb 2006 – 1 Septe 2025
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 – 1 Sept 2025
Mr Matthew Anstee	25 Feb 2021 – 1 Sept 2025
Ms Wendy Boddison	7 Sept 2004 – 9 June 2023
Ms Venetia Bombas	10 June 2013 – 9 June 2023
Ms Melissa Bray	25 Feb 2021 – 1 Sept 2025
Ms Meghan Butterfield	10 June 2018 – 9 June 2023
Mr Andrew Carson	3 Sept 1996 – 9 June 2023
Mr Jeremy Cass	25 Feb 2021 – 1 Sept 2025
Ms Arna Delle-Vergini	10 June 2018 – 9 June 2023
Ms Jennifer Ellis	25 Feb 2016 – 1 Sept 2025
Ms Susan Gribben	5 Sept 2000 – 9 June 2023
Ms Tamara Hamilton-Noy	25 Feb 2016 – 1 Sept 2025
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 Alison Murphy	25 Feb 2016 – 1 Sept 2025
Ms Fotini Panagiotidis	25 Feb 2021 - 1 Sept 2025
Ms Susan Tait	10 June 2013 – 9 June 2023
Ass Prof Michelle Taylor-Sands	10 June 2013 – 9 June 2023
Mr Jayr Teng	25 Feb 2021 – 1 Sept 2025
Dr Andrea Treble	23 July 1996 – 1 Sept 2025
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 Magdalena Wysocka	25 Feb 2021 – 1 Sept 2025

Psychiatrist Members	Period of Appointment
Dr Peter Adams	10 June 2018 – 9 June 2023
Dr Shruti Anand	25 Feb 2021 – 1 Sept 2025
Dr George Antony	25 Feb 2021 – 1 Sept 2025
Dr Mark Arber	25 Feb 2016 – 1 Sept 2025
Dr Robert Athey	9 Oct 2012 – 1 Sept 2025
Dr Anthony Barnes	6 Nov 2019 – 9 June 2023
Dr David Baron	22 Jan 2003 – 1 Sept 2025
Dr Fiona Best	10 June 2013 – 9 June 2023
Dr Joe Black	11 March 2014 – 9 June 2023 *(Retired 12 November 2020)*
Prof Sidney Bloch	14 July 2009 – 9 June 2023
Dr Ruth Borenstein	10 June 2018 – 9 June 2023
Dr Daniel Brass	25 Feb 2021 – 1 Sept 2025
Dr Peter Braun	25 Feb 2021 – 1 Sept 2025
Dr Pia Brous	10 June 2008 – 9 June 2023
Dr Peter Burnett	10 June 2018 – 9 June 2023
Dr Robert Chazan	25 Feb 2016 – 1 Sept 2025
Dr Peter Churven	10 June 2018 – 9 June 2023
Dr Eamonn Cooke	14 July 2009 – 9 June 2023
Dr Blair Currie	9 Oct 2012 – 1 Sept 2025
Assoc Prof John Fielding	11 March 2014 – 9 June 2023 *(Deceased 2 November 2020)*
Dr Joanne Fitz-Gerald	25 Feb 2016 – 1 Sept 2025
Dr Stanley Gold	10 June 2008 – 9 June 2023
Dr Fintan Harte	13 Feb 2007 – 1 Sept 2025
Dr Harold Hecht	9 Oct 2012 – 1 Sept 2025
Dr David Hickingbotham	25 Feb 2016 – 1 Sept 2025
Dr Stephen Joshua	27 July 2010 – 1 Sept 2025
Dr Spridoula Katsenos	9 Oct 2012 – 1 Sept 2025
Dr Diana Korevaar	25 Feb 2021 – 1 Sept 2025
Dr Miriam Kuttner	7 Sept 2004 – 9 June 2023
Dr Stella Kwong	29 June 1999 – 1 Sept 2025
Dr Jennifer Lawrence	9 Oct 2012 – 1 Sept 2025
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 Barbara Matheson	9 Oct 2012 – 1 Sept 2025
Dr Peter McArdle	14 Sept 1993 – 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 – 1 Sept 2025
Prof Daniel O'Connor	27 June 2010 – 1 Sept 2025
Dr Nicholas Owens	10 June 2013 – 9 June 2023
Dr Philip Price	10 June 2018 – 9 June 2023
Dr Philip Roy	09 Oct 2012 – 1 Sept 2025
Dr Amanda Rynie	25 Feb 2016 – 1 Sept 2025
Dr Rosemary Schwarz	25 Feb 2016 – 1 Sept 2025 *(Retired 7 February 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
Assoc Prof Dean Stevenson	25 Feb 2021 – 1 Sept 2025
Dr Jennifer Torr	11 March 2014 – 9 June 2023
Dr Maria Triglia	25 Feb 2011 – 1 Sept 2025
Assoc Prof Ruth Vine	9 Oct 2012 – 1 Sept 2025
Dr Susan Weigall	10 June 2018 – 9 June 2023

Registered Medical Members	Period of Appointment
Dr Adeola Akadiri	25 Feb 2021 – 1 Sept 2025
Dr Trish Buckeridge	1 July 2014 – 9 June 2023
Dr Louise Buckle	1 July 2014 – 9 June 2023 *(Retired 11 September 2020)*
Dr Kaye Ferguson	25 Feb 2016 – 1 Sept 2025
Prof Charles Guest	25 Feb 2021 – 1 Sept 2025
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 – 1 Sept 2025
Dr Debbie Owies	1 July 2014 – 9 June 2023
Dr Stathis Papaioannou	1 July 2014 – 9 June 2023

Community Members	Period of Appointment
Dr Nadja Berberovic	25 Feb 2021 – 1 Sept 2025
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 – 1 Sept 2025
Ms Sara Duncan	10 June 2013 – 9 June 2023
Ms Angela Eeles	10 June 2018 – 9 June 2023
Cr Josh Fergeus	25 Feb 2021 – 1 Sept 2025
Mr Harry Gelber	25 Feb 2021 - 1 Sept 2025
Mr Bernard Geary	10 June 2018 – 9 June 2023 *(Retired 9 February 2021)*
Ms Jacqueline Gibson	10 June 2018 – 9 June 2023
Mr John Griffin	25 Feb 2011 – 1 Sept 2025
Prof Margaret Hamilton	25 Feb 2016 – 1 Sept 2025
Ms Philippa Hemus	25 Feb 2021 – 1 Sept 2025
Mr Ben Ilsley	10 June 2013 – 9 June 2023
Ms Erandathie Jayakody	10 June 2018 – 9 June 2023
Mr Jie (George) Jiang	25 Feb 2021 – 1 Sept 2025
Mr John King	1 June 2003 – 1 Sept 2025
Ms Danielle Le Brocq	10 June 2013 – 9 June 2023
Mr John Leatherland	25 Feb 2011 – 1 Sept 2025
Ms Anne Mahon	10 June 2013 – 9 June 2023
Dr Kylie McShane	29 June 1999 – 1 Sept 2025
Dr Patricia Mehegan	10 June 2008 – 9 June 2023
Ms Sarah Muling	25 Feb 2016 – 1 Sept 2025
Mr Aroon Naidoo	25 Feb 2016 – 1 Sept 2025
Mr Jack Nalpantidis	23 July 1996 – 1 Sept 2025
Ms Linda Rainsford	10 June 2013 – 9 June 2023
Ms Lynne Ruggiero	10 June 2013 – 9 June 2023
Ms Veronica Spillane	25 Feb 2011 – 1 Sept 2025
Ms Helen Steele	25 Feb 2016 – 1 Sept 2025
Ms Charlotte Stockwell	10 June 2013 – 9 June 2023
Mr Anthony Stratford	10 June 2018 – 9 June 2023 *(Retired 28 October 2020)*
Ms Zara van Twest Smith	25 Feb 2021 – 1 Sept 2025
Dr Penny Webster	25 Feb 2006 – 1 Sept 2025
Prof Penelope Weller	10 June 2013 – 9 June 2023

Appendix D
Compliance reports

In 2020-21, the Tribunal maintained policies and procedures concerning the *Freedom of Information Act 1982* (the FOI Act), the *Public Interest Disclosures Act 2012* (the PID 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 23 requests for access to documents. In 11 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. Eight of the requests were withdrawn or were not proceeded with, no documents were found in relation to one request and one request had not yet been finalised on 30 June.

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 *Public Interest Disclosure Act 2012*

The PID 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 PID 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 2020-21 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 or the Independent Broad-based Anti-Corruption Commission (IBAC). The Department's contact details are as follows:

Department of Health
GPO Box 4057
Melbourne VIC 3001
Telephone: 1300 131 431
Email: publicinterestdisclosure@health.vic.gov.au

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

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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