Mental Health Tribunal

# Annual Report 2024-2025

Mental Health Tribunal

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Mental Health Tribunal

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30 August 2025

The Honourable Ingrid Stitt MP
Minister for Mental Health
50 Lonsdale Street
Melbourne Vic 3000

Dear Minister

I am pleased to present the Mental Health Tribunal's annual report of its operations for the period 1 July 2024 to 30 June 2025.

Yours sincerely

Matthew Carroll
President

# President's Message

**Our 2023–24 annual report highlighted a 19% increase in the number of hearings conducted by the Tribunal over the previous two years (2022–23 and 2023–24). It is with some astonishment this year we are reporting a further increase of 17%. To put this into perspective, in 2022–23 the Tribunal conducted 10,042 hearings. In 2024–25, the Tribunal conducted 13,029 hearings.**

With such significant increases, there is a focus on trying to understand why the number of hearings are increasing so dramatically. As we noted last year, a key factor is legislative changes, particularly the reduced maximum duration of a community treatment order from 12 to six months – but this isn't a full explanation.

Being limited to hearings, the Tribunal's data cannot itself identify these factors, but it can tell us more than simply how many hearings we conduct. In 2024–25, the Tribunal adopted a different approach to analysing its data to understand the number of individuals having a Tribunal hearing, how frequently they have a hearing, and the reasons for the hearing.

Part Two of this annual report includes this analysis, which will be an ongoing feature of our reporting. Examining our data this way identified the Tribunal is conducting hearings for 628 more people compared with 2022–23, and that in 2024–25 we conducted an average 2.1 hearings for each person.

Managing the increase in hearings has been extremely demanding, especially when the increase spiked. In some months, the year-on-year increase approached 25%. On three occasions when hearing demand exceeded capacity, the Tribunal's Registry implemented a Priority Listing Strategy to ensure a systematic and consistent approach in prioritising hearings for listing. The Tribunal notified stakeholders at the time that demand was exceeding capacity. In the interests of further transparency, Part 1 of this annual report provides an explanation of what the Priority Listing Strategy meant in practice.

I am relieved to confirm that in 2024–25, the Tribunal succeeded in conducting all hearings required under the *Mental Health and Wellbeing Act 2022*. I wish to acknowledge that to achieve this, we sometimes needed to reschedule listed hearings, or delay the listing of stand-alone patient applications to have a treatment order revoked. We sincerely regret when this was required and acknowledge that for each person whose application was delayed, and for the parties to a hearing that was rescheduled, this must have been frustrating.

It is impossible to predict hearing numbers over the next year. The Tribunal is being supported to maintain its capacity but like all organisations, our capacity is finite. If there are increases in demand equivalent to the past three years, the Tribunal will almost certainly reach a point where not all hearings required under the Act will be conducted. If this occurs, we have a strategy for communicating with parties, including explaining the consequences of a hearing not proceeding. We will report on this in our quarterly activity reports published on our website, and in our 2025–26 annual report.

The impact of increased numbers of hearings extends beyond the listing and conduct of those matters. While this is another area where multiple factors are at play, the increase in hearings has contributed to an 82% increase in the number of statements of reasons prepared compared to 2022–23. This has significantly increased the workload for Tribunal members and staff.

Furthermore, when an organisation is so relentlessly busy, the equally essential work of maintaining corporate systems and support increases at a commensurate rate and places enormous demands on the staff responsible for these 'back-of-house' systems.

Within such a highly pressured environment, when we developed the Tribunal's Strategic Plan 2025–2028 (see Part 3 of this annual report) while continuing our long-standing commitment to innovation and improving hearings for parties, we made a deliberate and prominent commitment to the wellbeing of members and staff. The work undertaken by members and staff is taxing in terms of volume, and the nature of our work is complex and demanding. The Tribunal has always placed significant importance on the wellbeing of its people, but we wanted to elevate that focus and commit to doing more.

Alongside our core business of hearings, the Tribunal advanced key projects and initiatives. Of particular significance is the Valuing Lived Experience at the Tribunal project to develop an overarching framework to guide our ongoing efforts to contribute to the Royal Commission's vision of centring and elevating lived experience within the mental health system. We recognise that lived experience is not just valuable, but essential. The insights of people who have experienced mental health challenges, and those who support them, help us make better decisions. We are honoured to work alongside lived experience members, advisors and partners in our ongoing efforts to ensure the Tribunal is inclusive, trauma-informed and solution-focused. As previous annual reports demonstrate, this is a longstanding focus of the Tribunal and we are proud of our achievements. The initiation and outcomes of the Valuing Lived Experience project reflect this work is never 'done' but is ongoing, and we must challenge ourselves to maintain what has been achieved and further ahead.

Member professional development has been a continuing focus. Alongside our well-established program of member forums and twilight seminars, in 2024–25, the Tribunal developed a 'tribunal-craft' education program. Tribunal-craft refers to the skills, knowledge and practices employed by tribunal members to conduct fair and effective hearings and can be thought of as comprising two layers. The first layer is universal, in that the craft is applicable to all tribunals; the second layer is local – the granular content that reflects the specific role of a particular tribunal. A pilot of the program was launched in May 2025 and will be completed in September 2025. The pilot will inform refinement of the content, and decisions about how the program is most effectively delivered in future.

This year also included a member appointment round. The scale and complexity of member appointments is difficult to capture. Appointments are a 12-month project undertaken in partnership with the Mental Health and Wellbeing Division in the Department of Health. I acknowledge the support of departmental staff with the standard appointment round (for appointment of members to commence on 2 September 2025) as well as a parallel, expedited process to appoint a small cohort of desperately needed legal members in December 2024.

It is important to recognise the impact of increased hearing numbers on administrative staff at health services who work with the Tribunal to coordinate hearings. Clinical staff who prepare reports and participate in hearings are also impacted, along with legal service providers who provide consumers with legal representation. We know the current volume of hearings creates challenges for all and appreciate your efforts to work effectively alongside the Tribunal to ensure the rights of consumers receiving compulsory treatment are upheld.

In concluding, I don't wish to simply thank but instead applaud the effort and contribution of Tribunal members and staff. The demands of this year have been relentless, but members and staff have been unwavering in their commitment to discharging the responsibilities of the Tribunal to the highest standards, while supporting each other in our work.

**Matthew Carroll**
President

## Membership changes during 2024-25

This year we welcomed four new legal members to the Tribunal:

Ms Catherine Clarke

Mr Joel Orenstein

Ms Kristen Rose

Ms Helen Syme

Some members retired from their appointment to the Tribunal and we acknowledge the dedication and contribution of, and say farewell, to:

**Community Member**

Prof Margaret Hamilton

**Legal Members**

Ms Carrie O'Shea

Mr Tony Lupton

**Psychiatrist Members**

Dr Nicholas Owens

Dr John Serry

We also want to acknowledge the passing of Dr Peter Burnett who served as a psychiatrist member of the Tribunal since June 2018.

# Introduction to the Mental Health Tribunal

**The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the Victorian *Mental Health and Wellbeing Act 2022* (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 the relevant criteria in the Act 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 for interstate transfers
- applications concerning intensive monitored supervision
- applications to perform neurosurgery for mental illness.

## Our vision

That the principles and objectives of Victoria's mental health legislation are reflected in the experience of consumers and carers.

## Our mission

The Tribunal decides whether a person receives compulsory treatment under Victoria's mental health legislation. Our hearings focus on human rights, recovery, least restrictive treatment and the participation of consumers, carers and clinicians.

## Our values

We seek to elevate lived experience and the voices of consumers and carers and are:

- Fair
- Respectful
- Collaborative.

## Our obligations regarding the mental health and wellbeing principles

Under section 333 of the Act, the Tribunal must in the performance of a function or duty, or the exercise of a power under the Act:

- give proper consideration to the mental health and wellbeing principles
- ensure that decision-making processes are transparent
- consider ways to promote good mental health and wellbeing.

To discharge its obligation to give the principles 'proper consideration' the Tribunal must seriously turn its mind to the possible impact of the principles on the decision and the implications on the person affected. In addition, section 10 of the Act states that in interpreting the Act, a construction that would promote the mental health and wellbeing principles is to be preferred to a construction that would not promote those principles.

## 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.

## Reconciliation Statement

The Tribunal acknowledges the Traditional Owners of the lands on which we work. We pay our respects to Elders, past and present. We acknowledge their continuing connection to Country and culture.

We acknowledge that colonisation, racism, discrimination, marginalisation and the compounding impact of intergenerational trauma have had a profound and enduring impact on mental health outcomes for Aboriginal and Torres Strait Islander peoples.

We acknowledge the negative experiences of Aboriginal and Torres Strait Islander peoples with our legal system have contributed to mistrust and a lack of confidence in those decision-making bodies and legal processes. As a consequence, there is a need to build relationships, respect and trust between the Tribunal and Aboriginal and Torres Strait Islander peoples.

The mental health and wellbeing principles enshrined in the Act require that when decisions are being made under the Act, proper consideration must be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country, and water.

We commit to listening, learning, and working with Aboriginal and Torres Strait Islander peoples in Victoria to improve access to our services across the state. Our vision is for a Tribunal that is culturally aware, sensitive, inclusive, and safe. Recognition and inclusion of Aboriginal and Torres Strait Islander peoples in the Tribunal and in our hearing processes is paramount to this vision.

# Part One

## Functions, procedures and operations of the Mental Health Tribunal

### 1.1 The Tribunal's functions under the *Mental Health and Wellbeing Act 2022*

The functions of the Tribunal as set out in s332 of the Act are to hear and determine the following:

- a matter in relation to whether a treatment order should be made
- an application to revoke a temporary treatment order or a treatment order
- an application to review the transfer of a patient to another designated mental health service
- an application to perform electroconvulsive treatment on an adult who does not have capacity to give informed consent
- an application to perform electroconvulsive treatment on 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 a grant of leave of absence
- an application by a security patient for a review of a direction to be taken to another designated mental health service
- applications about the proposed interstate transfer of a compulsory patient
- applications for an intensive monitored supervision order
- an application by a patient or on a patient's behalf for a revocation of the patient's intensive monitored supervision order, and
- to perform any other function which is conferred on the Tribunal under the Act, any other Act, the regulations or the rules under the Act or any other Act.

#### 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 compulsory treatment criteria to make a treatment order are met.

The Tribunal must be satisfied that all of the compulsory treatment criteria apply to a person before making a treatment order. These criteria are:

- the person has mental illness and
- 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 and
- if the person is made subject to a treatment order the immediate treatment will be provided to the person and
- there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

When the Tribunal makes or confirms 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. If the Tribunal is making a treatment order it also determines the duration of a treatment order. The maximum duration of an order for adult patients is six months. Where the patient is under 18 years of age, the maximum duration of any treatment order is three months. If the Tribunal is *confirming* a treatment order the expiry date of that order remains the same and cannot be changed by the Tribunal.

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.

The patient's treating team is required to regularly reconsider both the need for an order (i.e. if the compulsory 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).

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 decision of the Tribunal must be to either revoke the order or confirm the order.

***Security patients***

A security patient is a patient who is subject to either a court secure treatment order or a secure treatment order.

A court secure treatment order (CSTO) is an order made by a court to enable the person to be compulsorily taken to, and detained and treated in, a designated mental health service. A court may make a CSTO where the person is found guilty of an offence or pleads guilty to an offence and the relevant provisions specified in the sentencing legislation apply. The order cannot exceed the period of imprisonment to which the person would have been sentenced had the order not been made.

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. Under 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 intervals of no more than six-months, 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 make an interstate transfer order if satisfied of the statutory test or refuse to make an interstate transfer order if not so satisfied.

### 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 in writing 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 the young person's medical treatment decision maker must 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 the person from suffering or continuing to suffer 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 a lesion is created in a person's brain for the purpose of treatment; or
- the use of intracerebral electrodes to create a lesion in a person's brain for the purpose of treatment; or
- the use of intracerebral electrodes to stimulate a person's brain without creating a lesion 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.

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 neurosurgery 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.

### 1.1.4 Intensive Monitored Supervision orders

An order to allow intensive monitored supervision can only be made for a compulsory, security or forensic patient detained at Thomas Embling Hospital. To make an intensive monitored supervision order the Tribunal must be satisfied that the person poses an ongoing, unacceptable risk of seriously endangering the safety of another person; and requires an immediate period of supervision in a space that limits contact with others to mitigate the risk. The Tribunal must also be satisfied that all less restrictive options have been tried and found ineffective and that the person will be able to receive treatment or therapeutic interventions if the order is made.

The Tribunal must list and complete the hearing of an application for an intensive monitored supervision order as soon as practicable and within five business days after receiving the application. Intensive monitored supervision orders have a maximum duration of 28 days. Patients subject to an intensive monitored supervision order (or a person on their behalf) can apply to revoke the order and in such cases the Tribunal must hold a hearing as soon as practicable after the application is made.

# Case Study

## Voluntary or compulsory treatment: the significance of an alternative treatment plan

When determining whether a person requires compulsory treatment, the Tribunal must apply the compulsory treatment criteria set out in section 143 of the *Mental Health and Wellbeing Act 2022*. Section 143(d) of the Act requires the Tribunal to consider whether *'there are no less restrictive means reasonably available to enable the person to receive the immediate treatment'*. The focus of this criterion is whether the person can be treated on a voluntary basis or whether they need to be compelled to have treatment under a treatment order. The Tribunal must consider the particular circumstances of each patient.

Section 143 of the Act sets out a step-by-step process for determining whether a treatment order is made. If the Tribunal is considering section 143(d), this means it will have decided that section 143(b)is satisfied and the patient needs immediate treatment to prevent a serious deterioration in their mental and/or physical health, and/or to prevent serious harm to them and/or another person. The Tribunal does not decide the specifics of that immediate treatment, but in broad terms it will have considered what the critical elements of immediate treatment need to be in order to prevent the relevant deterioration and harm. If a patient is proposing an alternative treatment plan to that put forward by their treating team, section 143(d) requires the Tribunal to consider whether the alternative plan can facilitate the immediate treatment that is needed.

In JJV [2025] VMHT 006, JJV applied to have his treatment order revoked, as he wanted to be treated voluntarily. JJV explained that making his own treatment decisions was important to his wellbeing, as he said that in a symbolic sense, becoming a voluntary patient would be an endorsement of him. He said he would have a different perception of his treatment if he could feel responsible for it.

At the hearing, JJV's treating team cited past instances of JJV ceasing his medication. The treating team believed that JJV had not yet developed sufficient understanding of his psychotic illness to reliably adhere to treatment. The treating team viewed the treatment order as a protective measure to ensure JVV continued to receive treatment. JJV stated he had been stable in the community for four months, saw a psychologist weekly, met the community team fortnightly, and also planned to see his general practitioner if he were a voluntary patient.

The Tribunal acknowledged the treating team's concerns that JJV may not have fully comprehended all aspects of his illness. However, it also considered JJV's evidence regarding his engagement with mental health services, his willingness to collaborate with the treating team, and his strong community supports. In light of this, the Tribunal accepted JJV's position that there would be no practical difference between the treatment he would receive under a compulsory treatment order and the treatment he would receive under his own voluntary treatment plan. Consequently, the Tribunal concluded that a treatment order was not necessary.

The case of NTC [2024] VMHT 020 illustrates that when the patient's treatment plan diverges from the plan proposed by the treating team it can still be sufficient to enable voluntary treatment. NTC had experienced a relapse of her illness, including panic attacks, which led her to present to hospital voluntarily for treatment. While she agreed hospitalisation was initially necessary, she told the Tribunal she felt like her rights had been violated by being made a compulsory patient, felt unsafe in hospital and considered that a prolonged stay would be counter-therapeutic. NTC was candid about her reluctance to take lithium, as recommended by the treating team, but acknowledged that it would be dangerous to abruptly stop medication. She explained she had previously weaned off medication under psychiatric supervision and intended to continue following her psychiatrist's advice.

NTC's lawyer informed the Tribunal that NTC had access to a private psychiatrist and psychologist through her health insurance, a supportive family, and a stable living arrangement with someone who could monitor her mental health post-discharge.

The treating team did not believe NTC could be managed less restrictively. They noted she had only recently agreed to take medication, continued to experience residual symptoms, and had a limited understanding of her mental illness. Their view was that NTC could be seen to minimise her symptoms and their impact on her actions and relationships. The treating team were concerned that NTC did not fully understand the risks of untreated mental illness or the importance of medication as part of her treatment.

The Tribunal acknowledged the treating team's concerns but found that NTC could be treated less restrictively as they were satisfied that NTC had a treatment plan that could ensure she received the immediate treatment she needed. Specifically, NTC had established access to a private psychiatrist and psychologist, and had supportive family and friends with experience in mental illness.

In contrast to the matters of JJV and NTC, in WTR [2025] VMHT 011, the Tribunal was not satisfied the patient's proposed alternative treatment plan would facilitate the immediate treatment that was needed. WTR stated that if he were not on a treatment order he would stop taking the medication prescribed by his treating team and would not be willing to engage with the treating team for ongoing support and checks of his mental health. WTR stated he preferred a holistic approach to his treatment, including talking therapy over medication. WTR shared he had recently converted to a new religion and found support within the church community. The Tribunal accepted the treating team's evidence that medication and case management support were essential to WTR's stability, noting that previous non-adherence had led to his relapse and hospitalisation. The Tribunal concluded the treatment WTR was willing to accept would not be adequate for managing his mental illness and there was no less restrictive means than a treatment order for him to receive the immediate treatment he needed.

## 1.2 Administrative procedures

### 1.2.1 Scheduling of hearings

The responsibility for scheduling hearings rests with the Tribunal's registry, who use information provided by health services to list matters. Registry liaises with staff at each of the health services to coordinate and confirm the Tribunal's hearings list.

### 1.2.2 Location and mode of hearings

The Tribunal conducts hearings for patients across 61 hospitals and clinical services known as venues. To assist in the effective coordination of hearings, the Tribunal sits regularly at each venue, generally on a weekly or fortnightly basis. Since February 2022 hearings have been conducted remotely via online video using Microsoft Teams.

For some patients it is identified that an online hearing is not suitable, and a request is made to the Tribunal for their hearing to be conducted with at least one Tribunal member attending the health service in person. This is known as a hybrid hearing. The process for requesting a hybrid hearing is available on the Tribunal website.

For more information about hearings see section 1.3.

### 1.2.3 Notice of hearing

A notice of a hearing is provided to the person who is the subject of the proceeding, the patient's treating psychiatrist and the following, if applicable:

- the nominated support person of the person who is the subject of the proceeding
- if the person who is the subject of the proceeding is under 16, the person's parent
- 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 primary non-legal mental health advocacy service provider
- if the person who is the subject of the proceeding is a security patient, whoever had custody of the person before the person became a security patient
- the Secretary to the Department of Families, Fairness and Housing, if that Secretary has parental responsibility for the person who is the subject of the proceeding under a relevant child protection order
- in certain matters the person's medical treatment decision maker and support person
- any other person or body joined as a party to 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 one to two days after the Tribunal receives the application.

In addition, 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 over 13,000 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 identified cases to support the participation of patients, carers, nominated persons and treating team members, and to facilitate the readiness of the matter to proceed on the date of hearing. Categories of matters that are case managed include:

- complex adjournments, including those where we need to ensure the participation of specified individuals at the next hearing
- hearings where the circumstances require the matter to be finalised urgently
- matters involving complexity and that may require an extended hearing
- 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 or their carer 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 and carers 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 persons. These information products are available on the Tribunal's website and in languages other than English. The Tribunal's website also links to other relevant websites; for example, Independent Mental Health Advocacy (IMHA), the three providers of legal representation services, and the Mental Health and Wellbeing Commission.

## 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, NMI or the provision of intensive monitored supervision. Each general division 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 ECT, NMI or the provision of intensive monitored supervision. Each special division is made up of a legal member, a psychiatrist member and a community member. The legal member is the presiding member.

The Act does allow some procedural matters relating to adjournments and withdrawals to be handled by a single-member division in certain circumstances.

### 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 also attend – something the Tribunal strongly encourages. 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 mental health and wellbeing principles 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 Act.

Alongside these resources, professional development opportunities for members are provided during the year including forums, twilight seminars and practice reflection groups.

The Members Performance Feedback Framework process (see Membership and staff of the Tribunal) informs 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, the Mental Health Legal Centre and the Victorian Aboriginal Legal Service can provide free advice and legal representation at hearings. Statistics relating to legal representation are shown in Part Two.

### 1.3.4 Decisions and orders

The Tribunal delivers its decision orally at the conclusion of the hearing. On the same day, the Tribunal registry prepares a written order. The order is sent to the health service by email, and also to the patient, either electronically via the health service if they are an inpatient, or by post if they are in the community. Any additional person who was notified of a hearing in accordance with the Act (see above at 1.2.3) is also provided with documents relating to the outcome.

### 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 outcomes and will attend a hearing if requested to do so by VCAT.

### 1.3.6 Statements of reasons

Parties to a 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 must 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 of reasons produced is distributed to the patient, their legal representative (if any), the authorised psychiatrist or psychiatrist of the relevant mental health service and any party joined by the Tribunal.

***Publication of statements of reasons***

The Act stipulates that in the performance of a function or duty, or in the exercise of a power under the Act, the Tribunal must ensure that decision making processes are transparent. In line with this obligation, the Tribunal de-identifies and publishes a selection of its statements of reasons on the AustLII website.

The Tribunal publishes selected 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 and wellbeing 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 links to the AustLII website.

### 1.3.7 Rules and Practice Notes

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

- the form of applications, clinical reports and attendance requirements
- applications to perform neurosurgery for mental illness
- 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.

**Any statement of reasons produced is distributed to the patient, their legal representative (if any), the authorised psychiatrist or psychiatrist of the relevant mental health service and any party joined by the Tribunal.**

# Case Study

**Why is immediate treatment needed? Exploring whether a person needs immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or others.**

When determining whether a person requires compulsory treatment, the Tribunal's second consideration – the criterion in section 143(b) of the Act – is whether because of the person's mental illness they need immediate treatment to prevent serious deterioration in their mental or physical health, or to prevent serious harm to themselves or others. These elements are distinct and so only one needs to be satisfied, although there is often some interconnection. A serious deterioration in a patient's mental health often triggers – or at least contributes to – the behavioural changes or decision-making that can cause serious deterioration in their physical health, or serious harm to the patient or others.

In QJF [2025] VMHT 004, QFJ was brought to hospital after displaying agitation and making threats of self-harm. At the hearing, QJF described the hospitalisation as exhausting and attributed his distress to external circumstances. QJF's legal representative informed the Tribunal that QJF was now accepting depot medication and was willing to attend the clinic for injections.

The treating team reported that QJF had a history of not taking oral antipsychotic medication, and that without treatment, his mental health deteriorated. They explained this deterioration affected QJF's mental state as well as his behaviour and decision-making, which became uncharacteristic and potentially harmful. The team also noted that when unwell, QJF tended to isolate and struggled with self-care. They expressed concern about QJF's recent decision to end his rental agreement and relocate, which they believed could lead to homelessness.

The Tribunal accepted the treating team's evidence and concluded that, at times when QJF hasn't had adequate treatment, his mental health had deteriorated and his behaviour had changed, leading him to behave in ways and make decisions that were harmful to himself. For this reason, the Tribunal was satisfied that QJF required immediate treatment to prevent a serious deterioration in his mental health and serious harm to himself.

Whether the focus in a particular hearing is the deterioration of mental or physical health, or harm to the patient or another person, for the criterion to be met it must be demonstrated that immediate treatment can play a preventative role.

In JYN [2024] VMHT 022, the Tribunal held a hearing to consider an application by JYN's treating team for a further treatment order. The team's report outlined JYN's mental health history, including post-traumatic stress disorder (PTSD), anxiety and depression stemming from a traumatic workplace incident. They argued that without immediate treatment, JYN faced several risks including deterioration in mental health, homelessness, further police involvement, re-traumatisation, and suicide.

JYN's legal representative argued that none of these risks were imminent. She noted that JYN's suicide attempt had occurred when she was aged in her 20s and she now had stable housing. She emphasised that JYN had successfully managed her mental health without treatment or medication for years. JYN told the Tribunal that therapy had equipped her with strategies to manage PTSD and stress, and she wished to stop taking antipsychotic medication because it made her feel sluggish and she wanted more energy to seek employment.

The Tribunal was not persuaded that immediate treatment was necessary to prevent a serious deterioration in JYN's mental health. It found she had demonstrated long-term self-management of her PTSD and the stressors leading to her admission had largely resolved. As the evidence failed to establish a clear link between the proposed treatment and prevention of the potential harms identified, the Tribunal briefly noted that it was also not satisfied the other limbs of the criterion – principally risk of harm to self or others – were met.

## 1.4 Membership and staff of the Tribunal

Details about the profile of the Tribunal's members and staff are included in the organisational chart at Appendix B, and a full list of members is available at Appendix C.

The membership of the Tribunal comprises community, legal, psychiatrist and registered medical practitioner members. Members of the Tribunal are appointed by the Governor in Council for terms of up to five years; members can be reappointed. The membership is organised in such a way that every two to three years the terms of appointment of approximately half the members end, which triggers a member appointment round.

***Member support and professional development***

The Tribunal's Member Performance Feedback Framework has been in place since 2018. It is well-embedded in the Tribunal's operations and underpinned by the Tribunal's Competency Framework and Principles of Conduct for members. As part of the feedback process, members undertake self-appraisal and receive feedback from other members, including the Deputy President or President.

The outcomes from these processes provide valuable information about member support and training needs, both for individual members and for the collective membership. This support and training can take the form of informal discussions and coaching, or the provision of specific, formal presentations at the various member training opportunities which occur throughout the year. As part of the ongoing professional development opportunities for members, the Tribunal holds forums, twilight seminars and practice reflection groups.

This year we have also commenced a pilot of a new ongoing professional development program for members known as the 'Tribunal craft project'.

***Staff support and development***

The staff of the Tribunal are Victorian public servants within the Department of Health, and are part of the Victorian public sector. Tribunal staff ultimately report to the President of the Tribunal.

As public servants, Tribunal staff have access to the full suite of skills training, professional development offerings, occupational health and safety support and employee assistance available to Department of Health staff.

In addition, localised induction and development activities are provided to Tribunal staff. Over the course of the 2025-2028 strategic plan, the Tribunal will develop a full competency framework specific to working at the Tribunal.

***Supporting the wellbeing of Tribunal members and staff***

The Tribunal's Strategic Plan 2025-2028 prioritises a focus on the wellbeing of Tribunal members and staff, especially in the context of sustained and significant increases in caseload.

During 2024-25, the Tribunal progressed several planned activities, specifically:

- establishing the Tribunal's strategy for valuing lived experience (see details in Part 3)
- completing a major redesign of the Tribunal's extranet website including reviewing guides and resources for Tribunal members to make them more user-friendly. This involved user research with 20 sessional members to identify members needs and restructuring Tribunal guidance to improve navigation and searchability. The next phase of this work will be to review, integrate and update guidance on particular topics
- consulting members on the challenges associated with hearings and working remotely. This will inform the Tribunal's broader wellbeing strategy for members and staff.

## 1.5 Working with our stakeholders

### 1.5.1 Stakeholder engagement

***Legal representatives***

Legal representation is provided by three services in Victoria. In addition to being a provider of legal services to people having Tribunal hearings with a focus on people receiving compulsory treatment in an inpatient setting, Victoria Legal Aid (VLA) has been leading the development of the Mental Health Legal Rights Service (MHLRS). The Mental Health Legal Centre (MHLC) facilitates the provision of pro-bono legal representation to people on compulsory treatment orders, with a particular focus on people receiving compulsory treatment in the community, and over the past three years has tripled the number of patients it represents. The Victorian Aboriginal Legal Service (VALS) provide casework, referrals and advice for Aboriginal clients with Tribunal matters. VALS have quadrupled the number of patients it represents in Tribunal hearings.

The Tribunal meets on a regular basis with VLA, MHLC and VALS to discuss issues of common interest and maintain effective working relationships.

***Independent Mental Health Advocacy***

Independent Mental Health Advocacy (IMHA) is the primary non-legal mental health advocacy service provider under the Act. The Act requires the Tribunal to notify IMHA of all hearings and orders. The Tribunal meets on a regular basis with IMHA to discuss issues of common interest and maintain effective communication and working relationships.

***Tribunal Advisory Group***

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

***Health services***

The Tribunal facilitates a Tribunal Working Group (TWG) to consult and engage with Area Mental Health Services (AMHS) about key administrative practices. The group includes representatives from each AMHS, providing the Tribunal with a valuable opportunity to improve engagement with these services. As of March 2025, the TWG meet quarterly.

During 2024-25, the TWG has worked together to:

- improve the documents and information provided at hearings and implement the Tribunal's updated Practice Note 4
- minimise delays for patient submissions to the Tribunal
- develop the Tribunal's August 2025 – July 2026 Venue Calendar
- learn more about VALS work with patients
- implement changes to the Tribunal's after-hours ECT service
- implement the Tribunal's Priority Listing Strategy.

Alongside the broad agenda and communication that occurs through the TWG, Tribunal Registry staff are in regular contact with each AMHS to respond to localised issues that are identified by either or both the Tribunal or a service.

***Survey of treating teams experience of Tribunal hearings***

In 2024-25, the Tribunal conducted its first survey of treating teams experience of Tribunal hearings. This received a strong response with 82 treating team members completing the survey.

Responses to the survey provided an invaluable perspective. The majority of treating team members rated their experience of all aspects of hearings positively, but many responses reflected on the tensions and difficulties that can arise both in hearings, as well as the lead up to and after the hearing. The Tribunal recognises the importance of understanding and reflecting on these perspectives for ongoing improvement. The survey informed the development of the Tribunal's new Strategic Plan for 2025-2028 (see Part Three).

***Other engagement activities***

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

- Department of Health
- Victorian Mental Illness Awareness Council (VMIAC)
- Tandem
- Mental Health and Wellbeing Commission
- Office of the Chief Psychiatrist
- Health Information Management Association Australia (Victoria) Mental Health Advisory Group (MHAG)
- Safer Care Victoria
- Centre for Mental Health Learning (CMHL)
- Mental Health Victoria

### 1.5.3 Quarterly Activity Report

The Tribunal is committed to gathering, reporting and using activity data to promote transparency in its functions, and to support effective decision making in its operations and governance. The Quarterly Activity Report provides a snapshot of how the Tribunal operates under the Act, including what decisions and orders are made alongside demographic data. Quarterly Activity Reports are published at the end of quarters one, two and three and are available on the Tribunal website.

### 1.5.4 Complaints and feedback

The Tribunal welcomes complaints and feedback as an opportunity to monitor, review and improve its services, practices and procedures. The Complaints and feedback policy is available on the Tribunal website. People can contact the Tribunal to provide feedback or make a complaint by email, letter or phone or by completing an online form via the website.

During 2024-25 the Tribunal received 10 complaints^* and 8 pieces of feedback. These related to:

| | Complaints | Feedback |
|---|---|---|
| Clarification of procedures | 1 | 5 |
| Conduct of hearings | 10 | 2 |
| Procedural fairness | 0 | 0 |
| Technical or administrative difficulty or error | 0 | 1 |
| Customer service | 0 | 0 |
| Total | 11 | 8 |

^ *Where multiple contacts are received about one hearing or issue these are counted once. Where a complaint is later withdrawn it is not counted.*

* *The number of complaints and feedback do not match the count of complaint or feedback types as each contact can raise multiple concerns.*

## Priority Listing Strategy

During 2024-25, the Tribunal experienced unprecedented growth in demand for hearings under the Act. This was on top of a significant increase in hearings in 2023-24.

While the intent of the Act is to reduce compulsory treatment, it was broadly anticipated hearings would initially increase due to the maximum duration of community treatment orders being reduced from 12 to six months. This required two Tribunal hearings rather than one for many consumers.

Recognising the shorter duration of orders would initially result in increased hearings the Tribunal planned for this and implemented measures to manage an estimated increase of 1,500 hearings per year. In 2023-24, which incorporated the first nine months operation of the Act, the Tribunal conducted an additional 1,087 hearings. By the end of the first quarter of 2024-25, hearings had increased by a further 23% compared to the same period the previous year and capacity to conduct all required hearings was precarious.

In November 2024, the Tribunal sent a communique to stakeholders outlining the pressures impacting hearing capacity and the measures taken to respond. At that time, the Tribunal had increased the number of divisions being convened and expanded its capacity from 48 (in June 2023) to 60 hearings per day. This constituted the limit of operational capacity, with little flexibility to absorb unplanned absences or further increases in demand.

To manage this pressure, the Tribunal implemented a Priority Listing Strategy over December 2024 to January 2025. This strategy was designed to ensure a transparent and consistent approach to the listing of hearings, taking into account both legal and clinical considerations.

The Priority Listing Strategy established three tiers of priority:

**Priority 1** – ECT applications for adults unable to give informed consent and for patients under 18.

**Priority 2** – hearings for patients who had not yet had a Tribunal hearing during their current episode of treatment.

**Priority 3** – hearings for patients who had already had a Tribunal hearing during their current episode of treatment.

The Priority Listing Strategy was enacted again in April 2025, and by June 2025 the increase in hearings was so entrenched that the strategy was no longer employed episodically, it was needed on an ongoing basis.

Alongside the efforts of staff, members and the understanding of parties to hearings, the Priority Listing Strategy contributed to the Tribunal being able to conduct all hearings required under the Act. However the strategy does impact on everyone involved in hearings, and it was developed as a tool for ad-hoc rather than ongoing use. Accordingly the Tribunal is conducting a thorough review of the strategy and its broader procedures for managing periods of time (whether brief or protracted) when demand for hearings exceeds capacity.

# Part Two

## Hearing statistics for 2024-25

### Key statistics at a glance*

| | 2024-25 | 2023-24^ | 2022-23^ |
|---|---|---|---|
| Hearings listed § | 17,735 | 15,775 | 14,376 |
| Hearings conducted | 13,029 | 11,129 | 10,041 |
| Hearings determined | 11,144 | 9,398 | 8,629 |
| Hearings adjourned | 1,885 | 1,731 | 1,412 |
| Treatment orders made/confirmed | 10,087 | 8,350 | 7,239 |
| Temporary treatment orders / Treatment orders revoked | 633 | 617 | 479 |
| ECT orders made | 664 | 507 | 530 |
| ECT applications refused | 90 | 77 | 60 |
| NMI hearings conducted | 5 | 4 | 3 |
| Statement of reasons requested | 434 | 348 | 239 |
| Applications to VCAT | 44 | 34 | 25 |

### Attendance at hearings

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Patient | 7,600 | 6,852 | 6,251 |
| Carers and family members | 2,530 | 2,385 | 2,266 |
| Nominated support persons | 348 | 269 | 236 |
| Guardians | 70 | 60 | 48 |
| Medical treatment decision makers | 44 | 27 | 39 |
| Support persons | 1,146 | 857 | 491 |
| Interpreters | 702 | 613 | 574 |
| Legal representatives | 2,148 | 1,903 | 1,411 |

** The figures in Parts 2.1 to 2.9 and Parts 2.12 to 2.15 represent determinations at substantive hearings and exclude hearings that were adjourned or finalised without a determination. In addition, the count of hearings in Part 2.15 excludes applications to deny access to documents.*

*§ 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 2022-23 and 2023-24 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

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

A case type can be defined as the 'trigger' for a hearing. For example, an application for another treatment order, an application by a patient seeking revocation of an order and an application to perform ECT 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 which gives rise to a second case type. Wherever practicable, the Tribunal Registry will list the two case types to one hearing at the same time. For the purpose of recording statistics, this scenario is counted as one hearing and two decisions.

## 2.1 Treatment orders

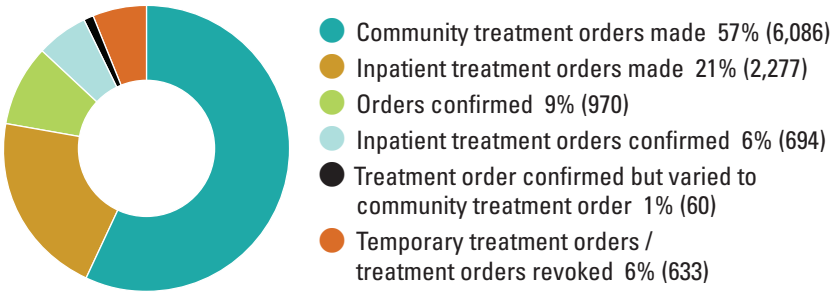
### 2.1.1 Outcomes of hearings regarding treatment orders (all case types)

In 2024-25, the Tribunal made a total of 8,363 treatment orders, confirmed 1,724 treatment orders and revoked 633 temporary treatment orders and treatment orders. There were six matters where the Tribunal found it did not have jurisdiction to conduct a hearing, and 153 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 another application if they wish to do so.

*Table 1: Determinations regarding treatment orders*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Community treatment orders made | **57% (6,086)** | 54% (4,845) | 61% (4,663) |
| Inpatient treatment orders made | **21% (2,277)** | 24% (2,164) | 33% (2,576) |
| Orders confirmed | **9% (970)** | 8% (753) | - |
| Inpatient treatment orders confirmed | **6% (694)** | 6% (530) | - |
| Treatment order confirmed but varied to community treatment order | **1% (60)** | 1% (58) | - |
| Temporary treatment orders / treatment orders revoked | **6% (633)** | 7% (617) | 6% (479) |
| **Total** | **100% (10,720)** | 100% (8,967) | 100% (7,718) |

*Figure 1: Determinations regarding treatment orders in 2024-25*



## 2.2 Treatment order hearing outcomes by case type

### 2.2.1 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. If making a treatment order, the Tribunal must also decide whether it is an inpatient or community treatment order and the duration of the treatment order.

*Table 2: Outcomes of 28-day hearings*

| | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| Community treatment orders made | **49% (1,952)** | 45% (1,569) | 48% (1,624) |
| Inpatient treatment orders made | **44% (1,740)** | 47% (1,619) | 45% (1,544) |
| Temporary treatment orders revoked | **7% (280)** | 8% (276) | 7% (254) |
| **Total** | **100% (3,972)** | 100% (3,464) | 100% (3,422) |

*Figure 2: Outcomes of 28-day hearings in 2024-25*


*Table 3: Duration of community treatment orders made in 28-day hearings*

| | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| 1–11 weeks | **4% (86)** | 7% (104) | 6% (99) |
| 12 weeks | **14% (267)** | 14% (226) | 16% (262) |
| 13–25 weeks | **14% (272)** | 15% (239) | 12% (194) |
| 26 weeks | **68% (1,327)** | 62% (974) | 53% (859) |
| 27–51 weeks | **–** | < 1% (1) | 1% (11) |
| 52 weeks | **–** | 2% (25) | 12% (199) |
| **Total** | **100% (1,952)** | 100% (1,569) | 100% (1,624) |

*Figure 3: Duration of community treatment orders made in 28-day hearings in 2024-25*

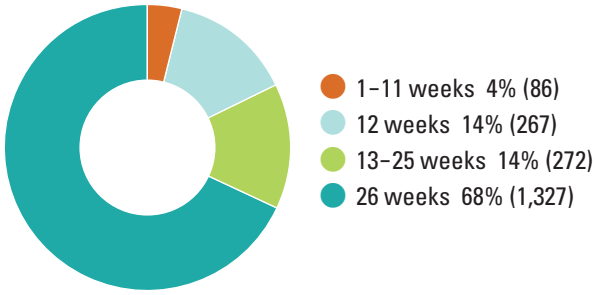
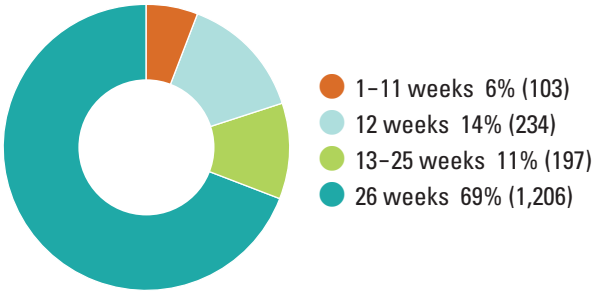


*Table 4: Duration of inpatient treatment orders made in 28-day hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| 1–11 weeks | **6% (103)** | 9% (145) | 9% (134) |
| 12 weeks | **14% (234)** | 16% (258) | 17% (267) |
| 13–25 weeks | **11% (197)** | 14% (231) | 10% (157) |
| 26 weeks | **69% (1,206)** | 61% (985) | 64% (986) |
| **Total** | **100% (1,740)** | 100% (1,619) | 100% (1,544) |

*Figure 4: Duration of inpatient treatment orders made in 28-day hearings in 2024-25*




The Tribunal revokes a temporary treatment order when one or more of the criteria for compulsory treatment in s143 of the Act is not met.

*Table 5: Reasons the Tribunal revoked temporary treatment orders in 28-day hearings**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| The person did not have a mental illness | **3%** | 3% | 2% |
| Immediate treatment was not necessary to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another person | **5%** | 7% | 3% |
| Immediate treatment was not able to be provided | **11%** | 12% | 9% |
| Immediate treatment was able to be provided in a less restrictive manner | **81%** | 78% | 86% |
| **Total** | **100%** | 100% | 100% |

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

### 2.2.2 Application for a further 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. After conducting the hearing, the Tribunal must either make a new treatment order or revoke the current treatment order. If making a treatment order, the Tribunal must also decide whether it is an inpatient or community treatment order and the duration of the treatment order.

*Table 6: Outcomes of authorised psychiatrist application hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Community treatment orders made | **85% (4,134)** | 83% (3,216) | 82% (2,724) |
| Inpatient treatment orders made | **11% (537)** | 12% (452) | 13% (433) |
| Temporary treatment orders revoked | **4% (198)** | 5% (204) | 5% (156) |
| **Total** | **100% (4,869)** | 100% (3,872) | 100% (3,313) |

*Figure 5: Outcomes of authorised psychiatrist application hearings in 2024-25*


*Table 7: Duration of community treatment orders made in authorised psychiatrist application hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| 1–11 weeks | **1% (53)** | 2% (45) | 1% (35) |
| 12 weeks | **6% (230)** | 6% (194) | 5% (142) |
| 13–25 weeks | **7% (294)** | 6% (195) | 5% (134) |
| 26 weeks | **86% (3,557)** | 81% (2,614) | 45% (1,225) |
| 27–51 weeks | **–** | < 1% (6) | 2% (42) |
| 52 weeks | **–** | 5% (162) | 42% (1,146) |
| **Total** | **100% (4,134)** | 100% (3,216) | 100% (2,724) |

*Figure 6: Duration of community treatment orders made in authorised psychiatrist application hearings in 2024-25*

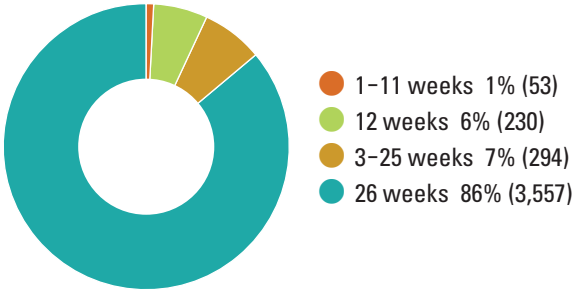
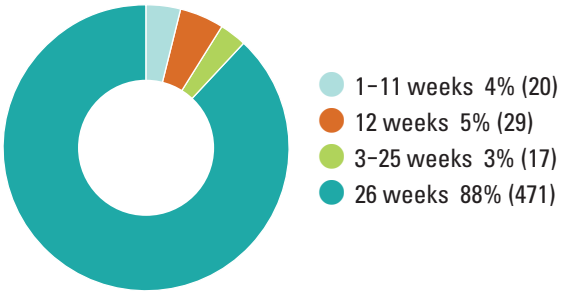


*Table 8: Duration of community treatment orders made in authorised psychiatrist application hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| 1-11 weeks | **4% (20)** | 5% (20) | 8% (35) |
| 12 weeks | **5% (29)** | 6% (29) | 9% (37) |
| 13-25 weeks | **3% (17)** | 6% (26) | 5% (22) |
| 26 weeks | **88% (471)** | 83% (377) | 78% (339) |
| **Total** | **100% (537)** | 100% (452) | 100% (433) |

*Figure 7: Duration of community treatment orders made in authorised psychiatrist application hearings in 2024-25*




As with temporary treatment orders, the Tribunal revokes a treatment order when one or more of the criteria for compulsory treatment in s143 of the Act is not met.

*Table 9: Reasons the Tribunal revoked treatment orders in authorised psychiatrist application hearings**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| The person did not have a mental illness | **3%** | 3% | 2% |
| Immediate 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 | **9%** | 6% | 5% |
| Immediate treatment was not able to be provided | **11%** | 13% | 9% |
| Immediate treatment was able to be provided ina less restrictive manner | **77%** | 78% | 84% |
| **Total** | **100%** | 100% | 100% |

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

### 2.2.3 Patients whose community treatment order was varied to an inpatient treatment order

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 confirm or revoke the treatment order, and if confirming the treatment order whether it should be for inpatient or community treatment. If confirming the treatment order, the Tribunal does not decide on a new duration, the confirmed treatment order's expiry date will be unchanged.

*Table 10: Outcomes of variation hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Community treatment orders made | – | 3% (19) | 10% (77) |
| Inpatient treatment orders made | – | 12% (91) | 85% (625) |
| Inpatient treatment orders confirmed | **87% (694)** | 71% (530) | - |
| Treatment orders confirmed but varied to community treatment order | **7% (60)** | 8% (58) | - |
| Treatment orders revoked | **6% (45)** | 6% (44) | 5% (39) |
| **Total** | **100% (799)** | 100% (742) | 100% (741) |

*Figure 8: Outcomes of variation hearings in 2024-25*


*Table 11: Reasons the Tribunal revoked treatment orders in variation hearings**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| The person did not have a mental illness | **0%** | 0% | 0% |
| Immediate 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%** | 0% | 0% |
| Immediate treatment was not able to be provided | **85%** | 73% | 85% |
| Immediate treatment was able to be provided in a less restrictive manner | **11%** | 27% | 15% |
| **Total** | **100%** | 100% | 100% |

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

### 2.2.4 Applications for revocation by the 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. After conducting the hearing, the Tribunal must either confirm the order or revoke the treatment order or temporary treatment order. If the patient's application concerns a treatment order, and the Tribunal decides to confirm the treatment order, it must also decide whether it is for inpatient or community treatment. If confirming the treatment order, the Tribunal does not decide on a new duration, the confirmed treatment order's expiry date will be unchanged.

*Table 12: Outcomes of revocation hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Community treatment orders made | – | 10% (94) | 55% (496) |
| Inpatient treatment orders made | – | 5% (53) | 35% (316) |
| Orders confirmed | **90% (970)** | 75% (753) | – |
| Temporary treatment orders or treatment orders revoked | **10% (110)** | 10% (102) | 10% (87) |
| **Total** | **100% (1,080)** | 100% (1,002) | 100% (899) |

*Figure 9: Outcomes of revocation hearings in 2024-25*


*Table 13: Reasons the Tribunal revoked temporary treatment orders / treatment orders in revocation hearings**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| The person did not have a mental illness | **2%** | 3% | 1% |
| Immediate 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 | **9%** | 13% | 10% |
| Immediate treatment was not able to be provided | **8%** | 5% | 5% |
| Immediate treatment was able to be provided in a less restrictive manner | **81%** | 79% | 84% |
| **Total** | **100%** | 100% | 100% |

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

## 2.3 ECT order applications related to adults

### 2.3.1 Outcomes of applications for an ECT order

In 2024-25, the Tribunal made decisions about 749 applications for an electroconvulsive treatment (ECT) order for an adult. ECT orders were made in 589 hearings for adult patients and 88 applications were refused. ECT orders were made in 70 hearings for adults being treated as voluntary patients and two applications were refused. When the Tribunal decides to make an ECT order it must also decide on the duration of the order and the authorised number of treatments.

*Table 14: Outcomes of applications for an ECT order*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| **ECT orders made** | | | |
| Adult patients | **589** | 440 | 475 |
| Adults not a patient | **70** | 64 | 51 |
| **ECT applications refused** | | | |
| Adult patients | **88** | 74 | 58 |
| Adults not a patient | **2** | 3 | 1 |
| **Total** | **749** | 581 | 585 |

The following tables and graphs provide details of the ECT orders made and applications refused, the duration of orders, number of ECT treatments authorised and timeframes for the hearing of applications.

*Figure 10: Determinations regarding applications for an ECT order in 2024-25*

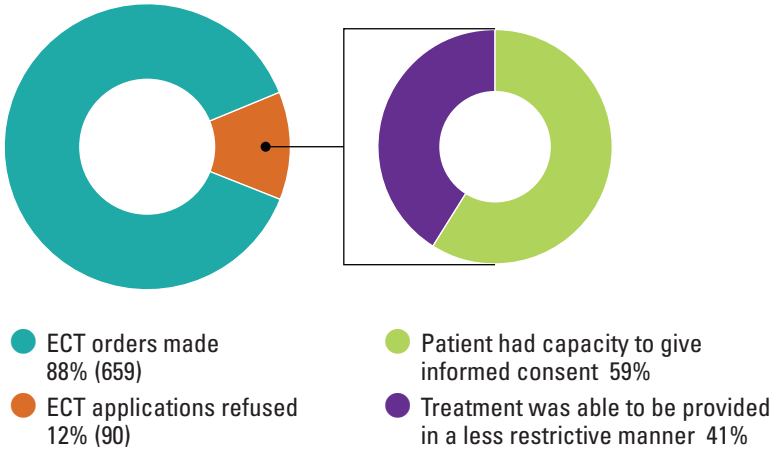



*Table 15: Determinations regarding applications for an ECT order*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| ECT orders made | **88% (659)** | 87% (504) | 90% (526) |
| ECT applications refused | **12% (90)** | 13% (77) | 10% (59) |
| **Total** | **100% (749)** | 100% (581) | 100% (585) |

*Table 16: Duration of ECT orders made*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| 1-11 weeks | **34% (223)** | 45% (225) | 46% (239) |
| 12 weeks | **24% (159)** | 17% (85) | 16% (86) |
| 13-25 weeks | **7% (44)** | 6% (33) | 10% (53) |
| 26 weeks | **35% (233)** | 32% (161) | 28% (148) |
| **Total** | **100% (659)** | 100% (504) | 100% (526) |

*Figure 11: Duration of ECT orders made in 2024-25*

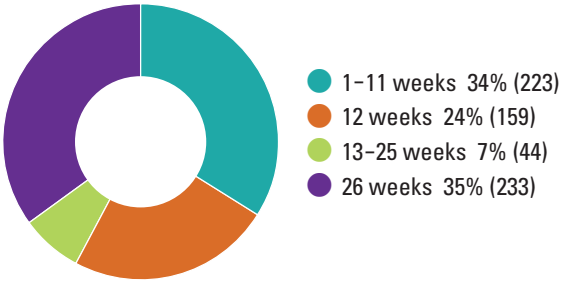



*Table 17: Number of ECT treatments authorised*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| 1-11 treatments | **4% (25)** | 7% (34) | 8% (42) |
| 12 treatments | **96% (634)** | 93% (470) | 92% (484) |
| **Total** | **100% (659)** | 100% (504) | 100% (526) |

*Figure 12: Number of ECT treatments authorised in 2024-25*

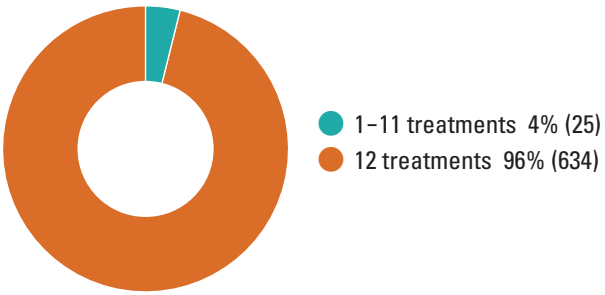


*Table 18: Reasons applications for an ECT order were refused**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Patient had the capacity to give informed consent | **59%** | 54% | 50% |
| Treatment was able to be provided in a less restrictive manner | **41%** | 46% | 49% |
| No instructional directive or written consent by the medical treatment decision maker | **0%** | 0% | 1% |
| **Total** | **100%** | 100% | 100% |

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

*Table 19: Proportion of applications for ECT orders which were urgent*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Urgent applications for ECT | **62% (462)** | 62% (359) | 66% (387) |
| Standard applications for ECT | **38% (287)** | 38% (222) | 34% (198) |
| **Total** | **100% (749)** | 100% (581) | 100% (585) |

*Figure 13: Proportion of applications for ECT orders which were urgent in 2024-25*


### 2.3.2 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. In 2024-25 the Tribunal heard seven urgent after-hours ECT applications all of which were granted.

### 2.3.2 Elapsed time from receipt of ECT applications to hearing

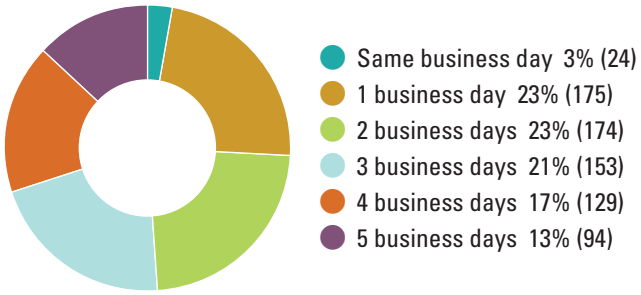
The Tribunal's Registry has detailed procedures that apply to the listing of ECT applications, including urgent applications. The Tribunal's listing processes consider patient participation in, and procedural fairness of, hearings, as well as the urgency of the application. Particular caution is taken 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.

*Table 20: Elapsed time from receipt of ECT applications to hearing*

| | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| Same business day | **3% (24)** | 3% (19) | 8% (48) |
| 1 business day | **23% (175)** | 21% (124) | 24% (138) |
| 2 business days | **23% (174)** | 25% (145) | 26% (153) |
| 3 business days | **21% (153)** | 19% (110) | 18% (103) |
| 4 business days | **17% (129)** | 19% (108) | 14% (84) |
| 5 business days | **13% (94)** | 12% (70) | 10% (58) |
| More than 5 business days | **0% (0)** | 1% (5) | < 1% (1) |
| **Total** | **100% (749)** | 100% (581) | 100% (585) |

*Figure 14: Elapsed time from receipt of ECT applications to hearing in 2024-25*



## 2.4 ECT order applications related to a young person under 18 years

***Compulsory patients***

During 2024-25, there was one application received in relation to a compulsory patient under 18 years of age. The application was granted.

***Voluntary patients***

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2024-25, the Tribunal received two applications concerning voluntary patients under 18 years old. Both applications were granted.

*Table 21: Determinations of ECT applications related to a young person*

| | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| **Compulsory patients – ECT orders made** | | | |
| Patient's age: 15 | **1** | 1 | 0 |
| Patient's age: 16 | **0** | 0 | 4 |
| Patient's age: 17 | **0** | 2 | 0 |
| **Compulsory patients – ECT applications refused** | | | |
| Patient's age: 16 | **0** | 0 | 1 |
| **Voluntary patients – ECT orders made** | | | |
| Patient's age: 15 | **2** | 0 | 0 |
| **Total** | **3** | 3 | 5 |

## 2.5 Neurosurgery for mental illness

In 2024-25, the Tribunal received five applications to perform neurosurgery for mental illness (NMI). All applications were granted.

*Table 22: Number and outcomes of applications to perform NMI*

| Application | Applicant mental health service | Diagnosis | Proposed treatment | Patient location | Hearing outcome |
|---|---|---|---|---|---|
| 1 | Royal Melbourne Hospital, Neuropsychiatry Centre | Obsessive-compulsive disorder | Deep brain stimulation | VIC | Granted |
| 2 | Royal Melbourne Hospital, Neuropsychiatry Centre | Obsessive-compulsive disorder | Deep brain stimulation | VIC | Granted |
| 3 | Royal Melbourne Hospital, Neuropsychiatry Centre | Obsessive-compulsive disorder | Deep brain stimulation | SA | Granted |
| 4 | Royal Melbourne Hospital, Neuropsychiatry Centre | Obsessive-compulsive disorder | Deep brain stimulation | NSW | Granted |
| 5 | Royal Melbourne Hospital, Neuropsychiatry Centre | Obsessive-compulsive disorder | Deep brain stimulation | VIC | Granted |

## 2.6 Security patients

During 2024-25, the Tribunal made 83 determinations in relation to security patients. The types of hearings and outcomes are detailed below

*Table 23: Determinations made in relation to security patients*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| **28-day review** | | | |
| Remain a security patient | **76** | 88 | 76 |
| Discharge as security patient | **4** | 3 | 2 |
| **6-month review** | | | |
| Remain a security patient | **0** | 0 | 1 |
| Discharge as security patient | **0** | 0 | 0 |
| **Application for revocation by the patient** | | | |
| Remain a security patient | **2** | 2 | 1 |
| Discharge as security patient | **1** | 3 | 0 |
| **Application by a security patient regarding leave** | | | |
| Application granted | **0** | 0 | 0 |
| Application refused | **0** | 0 | 0 |
| **Total** | **83** | 96 | 80 |

## 2.7 Applications to review the transfer of a patient's treatment to another service

During 2024-25, the Tribunal received four applications to review the transfer of a patient to another health service.

*Table 24: Determinations made in relation to applications to review transfer of treatment patient to another service*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Directed to remain subject to order as varied | **4** | 8 | 4 |
| Directed treatment by original treating service | **0** | 3 | 0 |
| **Total** | **4** | 11 | 4 |

## 2.8 Applications to transfer a person interstate

During 2024-25, the Tribunal received two applications to transfer an inpatient interstate.

*Table 25: Determinations made in relation to applications to transfer a person interstate*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Applications granted | **2** | 1 | 0 |
| Applications refused | **0** | 0 | 0 |
| **Total** | **2** | 1 | 0 |

## 2.9 Applications to deny access to documents

During 2024-25, the Tribunal received 264 applications to deny access to documents.

*Table 26: Determinations made in relation to applications to deny access to documents*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Applications granted | **242** | 192 | 124 |
| Applications refused | **22** | 13 | 15 |
| **Total** | **264** | 205 | 139 |

## 2.10 Applications for review by VCAT

In 2024-25, 44 applications were made to VCAT for a review of a Tribunal decision.

*Table 27: Applications to VCAT and their status*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Applications made | **44** | 34 | 25 |
| Applications withdrawn | **18** | 12 | 11 |
| Applications struck out | **0** | 0 | 1 |
| Applications dismissed | **2** | 4 | 4 |
| Hearings vacated | **1** | 1 | 7 |
| Decision set aside by consent | **0** | 0 | 0 |
| No jurisdiction | **0** | 1 | 2 |
| Applications proceeded to full hearing and determination | **21** | 11 | 12 |
| Applications pending at 30 June | **2** | 5 | 1 |

*Table 28: Outcomes of applications determined by VCAT*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Applications made | **18** | 9 | 9 |
| Applications withdrawn | **1** | 0 | 0 |
| Applications struck out | **4** | 2 | 3 |
| Applications dismissed | **1** | 0 | 0 |
| Other (Cases withdrawn, dismissed, vacated or pending) | **20** | 23 | 0 |

# Case Study

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

An application for an electroconvulsive treatment (ECT) order for an adult patient can only be granted if the Tribunal is satisfied the patient does not have capacity to give informed consent. A person has capacity if they are able to understand the information relevant to the decision about ECT; retain that information; use or weigh it in deciding whether to consent; and communicate their decision by speech, gestures or other means.

The 2018 case of PBU & NJE v Mental Health Tribunal [2018] VSC 564, which was decided under the previous Mental Health Act 2014, continues to guide Tribunal determinations about whether a person has capacity. That decision highlights the following key principles (among others):

1. The starting point is that a person is presumed to have capacity. Displacing this presumption is a decision with serious consequences for an individual and must be based on cogent evidence that persuades the Tribunal.
2. The test is functional. A person must have the ability to understand, retain, use or weigh relevant information and communicate a decision – they do not need to have actually done so.
3. The focus is on the process of decision-making, not the outcome. A person does not lack capacity simply because they make a decision others consider unwise.
4. Insight into one's mental illness or agreement with a diagnosis is not required to demonstrate capacity. While these factors may be relevant, they are not determinative.
5. The threshold for each domain of capacity is relatively low. This reflects the principles of self-determination, personal inviolability, and the right to be free from non-consensual medical treatment.

In many hearings, the Tribunal's decision turns on whether the person is able to use or weigh information in deciding whether to consent to ECT.

In OXQ [2024] VMHT 023, OXQ had experienced a relapse of her illness that resulted in a compulsory hospital admission. She told the Tribunal she did not believe she required any mental health treatment and felt she should be discharged immediately. OXQ believed the hospital admission was a mistake. She explained she had attended a police station to report concerns about her private psychiatrist and was subsequently taken to hospital by police. OXQ said she did not want to receive ECT, citing among other concerns her past experience of memory loss following ECT treatment.

The treating team informed the Tribunal they had made several attempts to explain and discuss ECT with OXQ but she was unable to engage in these discussions. According to the treating team, this was because OXQ believed the treating team's intentions were motivated by jealousy and they were seeking to harm her through the use of ECT.

The Tribunal identified factors that reinforced the presumption of capacity, as well as considerations that displaced it. Two factors that supported the presumption that OXQ was able to use or weigh information were: OXQ actively participated in a detailed discussion during the hearing, which stood in contrast to her earlier interactions with the treating team; and the Tribunal noted OXQ's ability to describe the ECT procedure and articulate her reasons for refusing it. Despite this, the Tribunal determined that OXQ lacked capacity, as at the time of the hearing, she appeared overwhelmed by her symptoms and unable to use or weigh information relevant to her decision.

In reaching this conclusion, the Tribunal placed particular weight on the fact that OXQ did not acknowledge any need for mental health treatment and believed that refusing ECT would result in an immediate discharge from hospital. The Tribunal also found that OXQ's thinking was impacted by delusional beliefs. For example, OXQ believed she was already being given ECT, that her treating team was acting out of jealousy, that ECT would shorten her life expectancy, and that some of the medications she was being given were part of an experiment. The Tribunal found these beliefs were not based in reality and concluded they impaired OXQ's ability to use or weigh information about ECT to make a decision.

In contrast, in MFG [2024] VMHT 024 the Tribunal concluded the patient did have the ability to use or weigh information about ECT. MFG had recently experienced a relapse of his mental illness, resulting in a four-week hospital admission. The treating team recommended ECT, citing his poor response to medication and the persistence of significant manic symptoms which included disorganised behaviour, disordered thinking, agitation and poor sleep. Although MFG expressed a desire to undergo ECT, the treating team believed that due to these symptoms he lacked the ability to understand and use or weigh the information provided about the treatment.

At the hearing, MFG reiterated his wish to proceed with ECT, stating he hoped it would help him start a new life, including plans to launch a business. He said he understood there was an 80% chance of ECT being effective and accepted that his doctors believed it was the best option for him.

The treating team acknowledged that MFG's mental state had improved significantly since his last review, conducted three days before the hearing. However, they remained concerned about the potential for rapid deterioration, noting fluctuations in his presentation during the admission.

In its reasons, the Tribunal agreed that MFG presented more positively at the hearing than described in the report the treating team had prepared for the hearing. He remained calm, composed, and aware of the recommended treatment. While the Tribunal acknowledged the treating team's concerns about his fluctuating mental state, it emphasised that capacity must be assessed based on the person's current presentation.

The Tribunal accepted that MFG understood the relevant information about ECT, was able to remember it, and could communicate his decision. Although his understanding of ECT was limited, the Tribunal noted this is not uncommon among individuals facing serious medical procedures. It emphasised that when applying the ECT criteria, decision-makers must avoid setting the threshold for capacity too high, as this risks discriminating against individuals with mental illness by holding them to a higher standard than others undergoing comparable treatments.

The Tribunal determined that MFG was able to use or weigh the relevant information. It found that MFG recognised he was unwell, wanted to improve, understood the risks of ECT, and accepted his doctors' advice that it was the best treatment for him. In reaching this conclusion, the Tribunal referred to the presumption of capacity under the Act, which requires that a person be presumed to have capacity unless proven otherwise on the basis of cogent evidence. The Tribunal considered MFG's views to reflect a typical response of a patient contemplating a significant medical procedure and choosing to follow medical advice.

Accordingly, the Tribunal refused the treating service's application for an ECT order. This did not mean ECT could not proceed. It meant that it could administered if MFG continued to provide informed consent.

## 2.11 Adjournments

The Act specifies a range of deadlines for the finalisation of hearings by the Tribunal.

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 broad 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. A matter may also be adjourned if the Tribunal is unable to constitute a three-member division.

*Table 29: Hearings adjourned*

| | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| Hearings adjourned without extending the order | **18% (332)** | 17% (302) | 16% (232) |
| Hearings adjourned with order extended | **82% (1,553)** | 83% (1,429) | 84% (1,180) |
| **Total** | **100% (1,885)** | 100% (1,731) | 100% (1,412) |
| Hearings adjourned as a percentage of total hearings conducted | **14%** | 16% | 14% |

*Figure 15: Hearings adjourned in 2024-25*

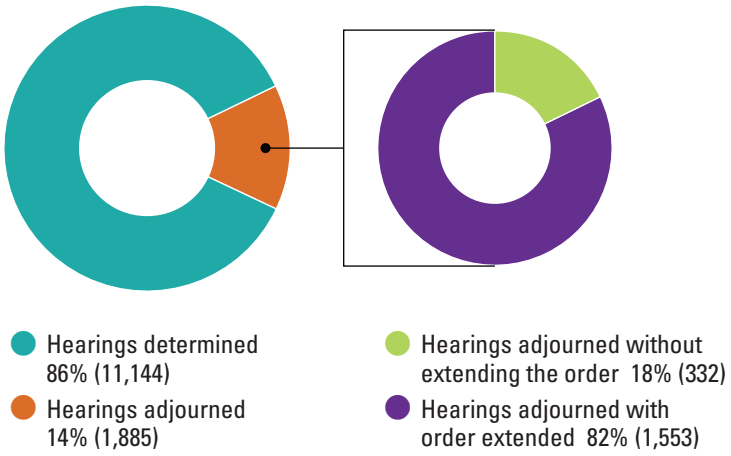
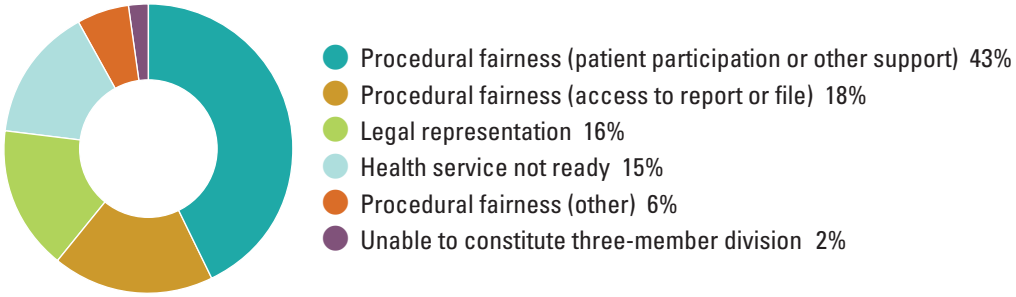


*Table 30: Reasons for adjournment with extension of order*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Procedural fairness (patient participation or other support) | **43%** | 42% | 47% |
| Procedural fairness (access to report or file) | **18%** | 19% | 18% |
| Legal representation | **16%** | 19% | 17% |
| Health service not ready | **15%** | 14% | 16% |
| Procedural fairness (other) | **6%** | 6% | 2% |
| Unable to constitute three-member division | **2%** | < 1% | < 1% |
| **Total** | **100%** | 100% | 100% |

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

*Figure 16: Reasons for adjournment with extension of order in 2024-25*




## 2.12 Hearings conducted by a single member division of the Tribunal

For a very limited range of procedural matters the Tribunal can be constituted by a single legal member. This requires the written approval of the President, and the Tribunal must report on the use of single member divisions in its annual report.

In 2024-25, there were no hearings conducted by a single member division of the Tribunal.

## 2.13 Attendance and legal representation at hearings

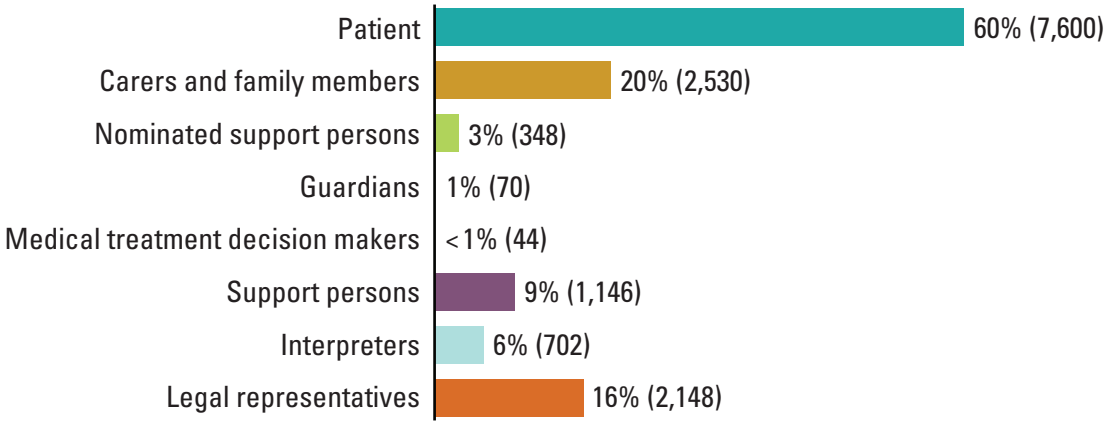
### 2.13.1 Attendance at hearings

The Tribunal strongly encourages the attendance of patients and those who support them at all hearings. As seen in Table 30, the most common reason for adjourning a hearing and extending a person's treatment order was to allow a further opportunity for the patient and/or their supporters to attend the hearing.

*Table 31: Number and percentage of hearings with patients and support persons in attendance*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Patient | **60% (7,600)** | 63% (6,852) | 63% (6,250) |
| Carers and family members | **20% (2,530)** | 22% (2,385) | 23% (2,265) |
| Nominated support persons | **3% (348)** | 2% (269) | 2% (236) |
| Guardians | **1% (70)** | 1% (60) | < 1% (48) |
| Medical treatment decision makers | **< 1% (44)** | < 1% (27) | < 1% (39) |
| Support persons | **9% (1,146)** | 8% (857) | 5% (491) |
| Interpreters | **6% (702)** | 6% (613) | 6% (574) |
| Legal representatives | **16% (2,148)** | 17% (1,903) | 14% (1,411) |

*Figure 17: Number and percentage of hearings with patients and support persons in attendance in 2024-25*



### 2.13.2 Legal representation at hearings

As noted in Part 1, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. In 2024-25, patients were legally represented in 2,148 (16%) hearings. The following table provides a more detailed breakdown of legal representation.

*Table 32: Legal representation at hearings*

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Victoria Legal Aid | **8% (1,029)** | 12% (1,281) | 10% (1,020) |
| Mental Health Legal Centre | **7% (968)** | 5% (518) | 4% (322) |
| Victorian Aboriginal Legal Service | **1% (110)** | < 1% (54) | < 1% (27) |
| Private Lawyer | **< 1% (37)** | < 1% (35) | < 1% (29) |
| Other Legal Aid | **< 1% (4)** | < 1% (15) | < 1% (13) |
| Total legal representatives | **2,148** | 1,903 | 1,411 |
| **Total hearings conducted** | **13,029** | 11,129 | 10,041 |

## 2.14 Compliance with statutory deadlines

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

*Table 33: Hearings not conducted within statutory deadlines*

| | 2024-25 |
|---|---|
| Cases received out of time | **2** |
| Hearings listed out of time | **1** |
| Hearings conducted out of time | **0** |
| Hearings adjourned by the Tribunal to be heard out of time | **4** |
| Hearings unable to proceed because the patient's treatment order had expired | **6** |
| **Total** | **13** |

## 2.15 Number of patients and hearings per patient

In early 2025, the Tribunal analysed hearing data differently to understand the number of individuals having a Tribunal hearing, how frequently they have a hearing, and the combined reasons for hearings. This was in the context of trying to identify the different factors that may be contributing to increased hearing demand.

This breakdown of our data will now be an ongoing feature of our Annual Report and the Quarter 2 Quarterly Activity Report.

*Table 34: Total number of patients and hearings**

| | 2024-25 | 2023-24 | 2022-23 |
|---|---|---|---|
| Number of hearings conducted | **12,723** | 10,893 | 9,880 |
| Number of patients | **6,172** | 5,618 | 5,544 |
| % change in hearings from previous year | **+17%** | +10% | +7% |
| % change in patients from previous year | **+10%** | +1% | +7% |
| Average number of hearings per patient | **2.1** | 1.9 | 1.8 |

** This count of hearings excludes applications to deny access to documents*

*Table 35: Number of hearings* conducted for each patient*

| | 2024-25 | | | 2023-24 | | | 2022-23 | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. of patients | % of patients | % of hearings conducted | No. of patients | % of patients | % of hearings conducted | No. of patients | % of patients | % of hearings conducted |
| 1 hearing | **2,447** | **40%** | **19%** | 2,591 | 46% | 24% | 2,955 | 53% | 30% |
| 2 hearings | **2,142** | **35%** | **34%** | 1,744 | 31% | 32% | 1,568 | 28% | 32% |
| 3 hearings | **889** | **14%** | **21%** | 761 | 14% | 21% | 641 | 12% | 19% |
| 4 hearings | **398** | **6%** | **12%** | 291 | 5% | 11% | 212 | 4% | 9% |
| 5+ hearings | **296** | **5%** | **14%** | 231 | 4% | 12% | 168 | 3% | 10% |
| **Total** | **6,172** | **100%** | **100%** | 5,618 | 100% | 100% | 5,544 | 100% | 100% |

** This count of hearings excludes applications to deny access to documents*

Except where individual circumstances prevent this or require a different approach, when the Tribunal conducts a hearing for a patient it will finalise all the outstanding cases for that patient. Having a snapshot of the case combinations within Tribunal hearings helps illustrate the decisions being made by both treating teams and the patient (that is, concerning applications to revoke) that necessitate a hearing.

*Table 36: Number of hearings*^ conducted by case combinations*

| | **2024-25** No. of hearings | 2023-24 No. of hearings | 2022-23 No. of hearings |
|---|---|---|---|
| 28-day hearing | **4,330** | 3,768 | 3,670 |
| 28-day hearing and application for revocation | **530** | 485 | 466 |
| Application for a further treatment order | **5,127** | 4,216 | 3,537 |
| Application for a further treatment order and application to revoke | **142** | 100 | 77 |
| Application for a further treatment order and variation hearing | **304** | 251 | 196 |
| Application for a further treatment order, application for revocation and variation hearing | **11** | 13 | 11 |
| Application for revocation | **756** | 719 | 584 |
| Variation hearing | **546** | 542 | 581 |
| Application for revocation and variation hearing | **82** | 59 | 55 |
| 28-day hearing (security patient) | **82** | 97 | 81 |
| 28-day hearing and application for revocation (security patient) | **3** | 1 | 2 |
| Application for revocation (security patient) | **0** | 4 | 1 |
| 6-month review (security patient) | **0** | 0 | 1 |
| Application for ECT (adult patient) | **718** | 546 | 552 |
| Application for ECT (young patient) | **3** | 3 | 5 |
| Application for ECT (adult not a patient) | **73** | 72 | 52 |
| Application for ECT (young person not a patient) | **2** | 0 | 0 |
| NMI | **5** | 4 | 3 |
| Application to transfer a patient interstate | **1** | 0 | 0 |
| Application to transfer a person interstate | **2** | 1 | 0 |
| Application to transfer patient to another service | **6** | 12 | 6 |
| **Total** | **12,723** | 10,893 | 9,880 |

** This count of hearings excludes applications to deny access to documents.*

*^ In order to align the count of hearings in tables 34 and 35 in Part 2.15, a hearing of an ECT application hasbeen included as a stand-alone hearing and not combined with a concurrent treatment order matter.*

## 2.16 Customer service

The Tribunal's service standards are published on our website and outline the standards people can expect from the staff of the Tribunal. These standards include that the Tribunal will answer 90% of phone calls within 30 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 2024-25, both service standards were met, with all email and website enquiries responded to in accordance with the service targets, and 90% of phone calls were answered within 30 seconds.

# Part Three

## The Tribunal's Strategic Initiatives

### 3.1 Development of our Strategic Plan 2025–2028

In 2024-25, the Tribunal finalised its Strategic Plan 2025-2028. As with previous strategic plans, its content was significantly driven by the input of the lived experience TAG, alongside that of Tribunal staff and members, and for the first time, staff in health services were surveyed to inform the Strategic Plan. Future reports will update on progress with implementing commitments made in the Strategic Plan.

Mental Health Tribunal

# Strategic Plan 2025-2028

## Our Strategic Priorities

### 1 Ensure fair, consistent and solution-focused hearings

**We continually strive to improve our skills and systems to deliver fair and solution-focused hearings that promote the mental health and wellbeing principles.**

**Over the life of this plan the Tribunal will:**

- Review and refine our continuing professional development program for Tribunal members focused on conducting hearings in the Tribunal's current operating environment.
- Further embed trauma-informed practice in the conduct of hearings.
- Work with representative bodies to identify and implement practices to make hearings more culturally safe and appropriate for First Nations consumers.
- Undertake further surveys of consumers, carers and treating teams to understand their experience of Tribunal hearings.

### 2 Continue to refine our hearing processes with a focus on operating flexibly and sustainably

**We will work with stakeholders to design and implement process reforms that provide high-quality hearings that are responsive to the needs of hearing participants.**

**Over the life of this plan the Tribunal will:**

- Collaborate with stakeholders and other entities on the development of standards for engagement with Tribunal hearings.
- Work with the Mental Health Legal Rights Service to optimise legal representation in hearings.
- Undertake a pilot to confirm the systems and resources needed to conduct some hearings in-person.

### 3 Support the wellbeing of Tribunal members and staff

**We are committed to maintaining an ongoing focus on the wellbeing of our members and staff, especially in the context of sustained and significant increases in the Tribunal's caseload.**

**Over the life of this plan the Tribunal will:**

- Develop a broader wellbeing strategy for members and staff that responds to the challenges associated with online remote work, and the Tribunal's increasingly complex operating environment.
- Elevate and embed lived experience in the Tribunal and create a safe and supportive environment for members and staff with lived experience as consumers and carers.
- Review our suite of member resources and performance supports including our extranet, principles of conduct, competency framework and performance feedback process.
- Review our approach to managing the professional development of Tribunal staff, including by developing a competency framework.
- Revisit and update the internal review of the Tribunal's structure to assess whether the Tribunal is positioned to respond to fluctuating demand and able to optimise member engagement.

**Our Mission**
The Mental Health Tribunal decides whether a person receives compulsory treatment under Victoria's mental health legislation. Our hearings focus on human rights, recovery, least restrictive treatment and the participation of consumers, carers and clinicians.

**Our Vision**
That the principles and objectives of Victoria's mental health legislation are reflected in the experience of consumers and carers.

**Our Values**
We seek to elevate lived experience and the voices of consumers and carers and are:
- Fair
- Respectful
- Collaborative.

Mental Health Tribunal

## 3.2 Embedding the lived experience principle set down in the Act

Section 21 of the Act reflects the foundational theme in the recommendations of the Royal Commission that the mental health and wellbeing system centre the voice of lived experience. Section 21 states:

> ***The lived experience of a person with mental illness or psychological distress and their carers, families and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.***

The Tribunal has a longstanding focus on embedding and elevating lived experience. In 2024-25 the Tribunal highlights its new Valuing Lived Experience project, and the ongoing partnership with the TAG .

### 3.2.1 The Valuing Lived Experience project

In 2024-25, the Tribunal undertook the Valuing Lived Experience at the Tribunal project. The objective was to create a framework and education strategy on valuing lived experience at the Tribunal.

Valuing lived experience within the Tribunal is essential for informed, person-centred outcomes. Individuals with lived experience offer critical insights that deepen understanding of the mental health system. They challenge systemic bias and foster a psychologically safe environment for all. Lived experience brings essential insight, wisdom and humanity to the Tribunal's work which is vital to fair, compassionate and effective decision-making.

Lived experience is embedded in the governance and leadership structures of the Tribunal. The Tribunal staff includes a dedicated Senior Adviser Lived Experience, who holds a position on the Tribunal Governance Group, and Leadership Team. The Tribunal Governance Group has two positions held on a rotational basis by Tribunal members with lived experience as a consumer, or carer. Lived experience is also integrated into the Tribunal's member appointment processes, with lived experience staff or members participating on selection panels for new appointments as well as for senior staff. Across the Tribunal lived experience perspectives help shape decisions that are more trauma-informed and solution-focused.

The Valuing Lived Experience Project methodology was guided by a human-centric design approach, ensuring that Tribunal members and staff – the primary users of the framework – remain at the centre of the process and outcomes. A human-centric approach emphasises inclusive and collaborative design with direct involvement of stakeholders in shaping outcomes.

The design process was informed by the 2024 Strategic Planning Survey, which gathered insights from Tribunal members and staff, including specific questions related to lived experience. These insights helped shape the project's direction and priorities.

Two co-design workshops were held with participation from members across all categories and Tribunal staff, including individuals with and without lived experience as consumers or carers. The workshops were facilitated by the Senior Adviser Lived Experience, and provided a structured space for dialogue, reflection and shared learning.

In addition to the workshops, the Tribunal's Lived Experience Working Group (LEWG) and Carers Network were consulted to provide input and feedback to the project. The TAG was also engaged to ensure alignment with broader organisational goals.

In May 2025 the final report from the project was endorsed by the Tribunal's Governance Group. The report made recommendations to embed lived experience more deeply into the Tribunal's operations.

The recommendations include:

- provide training for staff and members with a focus on lived experience awareness and trauma-informed practice to deepen understanding, promote inclusive practices, and reinforce appropriate boundaries in the use of lived experience within the Tribunal context
- continue strengthening the supports for Tribunal members and staff with lived experience, with a focus on psychological safety and inclusion in the workplace
- integrate lived experience competencies into the Tribunal Member Competency Framework
- include lived experience criteria in performance feedback processes to support continuous improvement.

These recommendations reflect the Tribunal's commitment to listening, as well as learning and evolving. Following endorsement of the project, the Tribunal adopted the following statement to articulate its approach to valuing lived experience:

> ***The Tribunal is dedicated to valuing and integrating lived experience into every aspect of our operations. We strive to create an inclusive and psychologically safe workplace where everyone is encouraged to bring their authentic selves to their role. Our commitment to respectful and recovery-focused language, including trauma-informed language, ensures a supportive and inclusive environment. By embedding lived experience into our practices, we ensure a supportive and inclusive atmosphere for all.***

The completion of the Valuing Lived Experience Project does not mean the focus now shifts or the work is completed. Embedding the lived experience principle is an ongoing priority of the Tribunal through implementation of the project recommendations as well as continuing to explore what more we can do.

### 3.2.2 Tribunal Advisory Group (TAG)

The TAG consists of consumers, carers and lived experience workforce members, together with a Senior Legal member, the Chief Executive Officer, and the Senior Adviser Lived Experience of the Tribunal. The role of the TAG is to provide strategic and operational advice to the Tribunal.

TAG members are engaged for up to two two-year terms. The Tribunal aims to renew up to half of the TAG membership every two years to maintain a balance of experienced members and new member perspectives.

In 2024–25, the TAG farewelled Nicholas Bloom, Francesca Macaulay, Natasha Gore, Jacqueline Rosario and Semonti Modak. The Tribunal thanks all of the outgoing TAG members for their significant contributions to the work of the Tribunal.

In 2024–25, the TAG welcomed two new members: Kerry Barrett as a Carer TAG member; and Miri Carter as a Consumer Workforce TAG member. Recruitment for additional TAG members will continue into 2025-26. The Tribunal looks forward to continuing to learn from the expertise TAG members bring to the Tribunal's work.

This year TAG members provided advice and input to several strategic activities, including:

- an initiative of the Mental Health and Wellbeing Commission to develop comprehensive guidance on the meaning, promotion and implementation of the mental health and wellbeing principles
- a review of the communications the Tribunal sends to consumers, with a particular focus on developing tools to assist them with preparing for Tribunal hearings such as the 'What I want to tell the Tribunal Worksheet'
- case studies included in the Tribunal Craft project for members.

## 3.3 Reconciliation and cultural safety in hearings

Since 2023, the Tribunal's Reflect Reconciliation Action Plan (RAP) has driven a number of initiatives across the Tribunal. The Tribunal has worked to build greater awareness through participation in the online training modules delivered by the Centre for Cultural Competence Australia, and sought to build deeper connections with key stakeholders and organisations such as VALS. Small but meaningful advances made have included adopting a Reconciliation Statement, and updating guidance to members for an Acknowledgement of Country before hearings proceed. The online background for Tribunal hearings includes the Australian, Aboriginal and Torres Strait Island flags.

The Tribunal's implementation of its RAP has been underway at a time with intense focus on cultural safety – or more correctly, the lack of cultural safety – in the provision of mental health and wellbeing supports to First Nations consumers. Over-representation of First Nations consumers in compulsory mental health assessment and treatment was examined by the Yoorrook Justice Commission (Yoorrook). In June 2024, Minister for Health, the Hon Mary Anne Thomas MP, made a commitment to Yoorrook that work being undertaken within the Department of Health to reduce compulsory treatment would take on an additional, specific focus of how to reduce compulsory treatment for First Nations consumers. The Tribunal is also aware that submissions to Yoorrook said that Tribunal hearings are not culturally safe given the role that courts and tribunals have played in dispossession and disempowerment; inherent power imbalances; systemic racism; and legislative as well as procedural limitations.

This is the context for the Tribunal's Strategic Plan 2025-2028, including a commitment to work with representative bodies to identify and implement practices to make hearings more culturally safe and appropriate for First Nations consumers. To have the capacity to do this, the Tribunal has needed to grapple with a vexing challenge. RAPs are complex instruments that require significant resources to develop and manage for an organisation to meet the requirements of Reconciliation Australia. As with every other aspect of current operations, the Tribunal has needed to test how to use its limited capacity most effectively. This has led the Tribunal to suspend its enrolment in the RAP process of Reconciliation Australia to focus on progressing what the Reflect RAP started– education, relationship building and focusing on how the Tribunal can deliver culturally safe hearings for First Nations consumers. The Tribunal approaches this with no preconceived ideas regarding what the model for culturally safe hearings may be. The Tribunal is open minded and keen to learn how the cultural safety principle set down in section 27 of the Act can be enlivened in Tribunal hearings.

## 3.4 Expanding professional development opportunities for members

The Tribunal has an obligation to support continuous professional development. Professional development involves providing opportunities to support, enhance or build on the practical skills required for members to undertake their role. It allows members to maintain a skill level which reflects the overarching goals of the Tribunal – ideally, setting a standard of excellence. Critically, professional development supports members and should contribute to their enjoyment of their role and to public confidence in the Tribunal.

In September 2023, the Tribunal surveyed members to seek their views about the level of professional development and support provided. A significant number identified a wish to further develop their skills in what is colloquially known as 'tribunal craft'. Members also requested a greater opportunity for interactive learning through group discussion and sharing experiences. This led to the development of a pilot program for the Tribunal Craft Project.

Tribunal craft may be defined as skills for conducting a hearing, which often come from experience (exposure). It encompasses important legal and practical considerations for hearings such as procedural fairness, acknowledging and dealing with bias, as well as other skills such as communication skills, trauma informed practice, working as a multidisciplinary panel, and solution-focused hearing practice.

The Tribunal Craft pilot was launched in May 2025 and will conclude in September 2025. It is led by full and part-time members of the Tribunal. The pilot group of 20 Tribunal members volunteered to participate and assist in further refinement. Topics include: the role of an inquisitorial Tribunal; attributes of a Tribunal member; decision-making; procedural fairness; communication skills (including working with interpreters); the solution-focused approach to hearings; styles of questioning; and managing the conduct of hearings.

The pilot will inform decisions about the substantive content of the Tribunal Craft Project, its delivery, and how it can most effectively become part of the Tribunal's professional development program.

**Professional development allows members to maintain a skill level which reflects the overarching goals of the Tribunal – ideally, setting a standard of excellence.**

# Appendix A: Financial data

### 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** | **2024-25** | 2023-24 | 2022-23 |
|---|---|---|---|
| **TOTAL** | **$11,793,290** | $13,041,551 | $10,927,231 |
| **Expenditure** | | | |
| Full and part-time member salaries | **$1,370,927** | $1,615,577 | $1,595,575 |
| Sessional member salaries | **$6,937,801** | $5,849,324 | $4,919,676 |
| Staff Salaries (includes contractors) | **$3,435,359** | $3,036,272 | $2,477,300 |
| Salary On costs | **$2,395,683** | $2,060,593 | $1,643,213 |
| Operating Expenses | **$696,710** | $818,825 | $640,587 |
| Total | **$14,836,480** | $13,380,591 | $11,276,351 |
| **Balance** | | | |
| **TOTAL** | **-$3,043,190*** | -$339,040* | -$349,120* |

**Annual deficits are supplemented by the Department of Health*

### Financial Reporting Direction 24: Reporting of environmental data by government entities

The Mental Health Tribunal utilises central government contracts for the provision of all its services including electricity provision, fleet and office fit outs. Relevant environmental data pertaining to Tribunal business activity under FRD24 is captured and reported in the whole of Victorian Government reporting.

# Appendix B: Workforce profile

Mental Health Tribunal workforce profile at 30 June 2025:

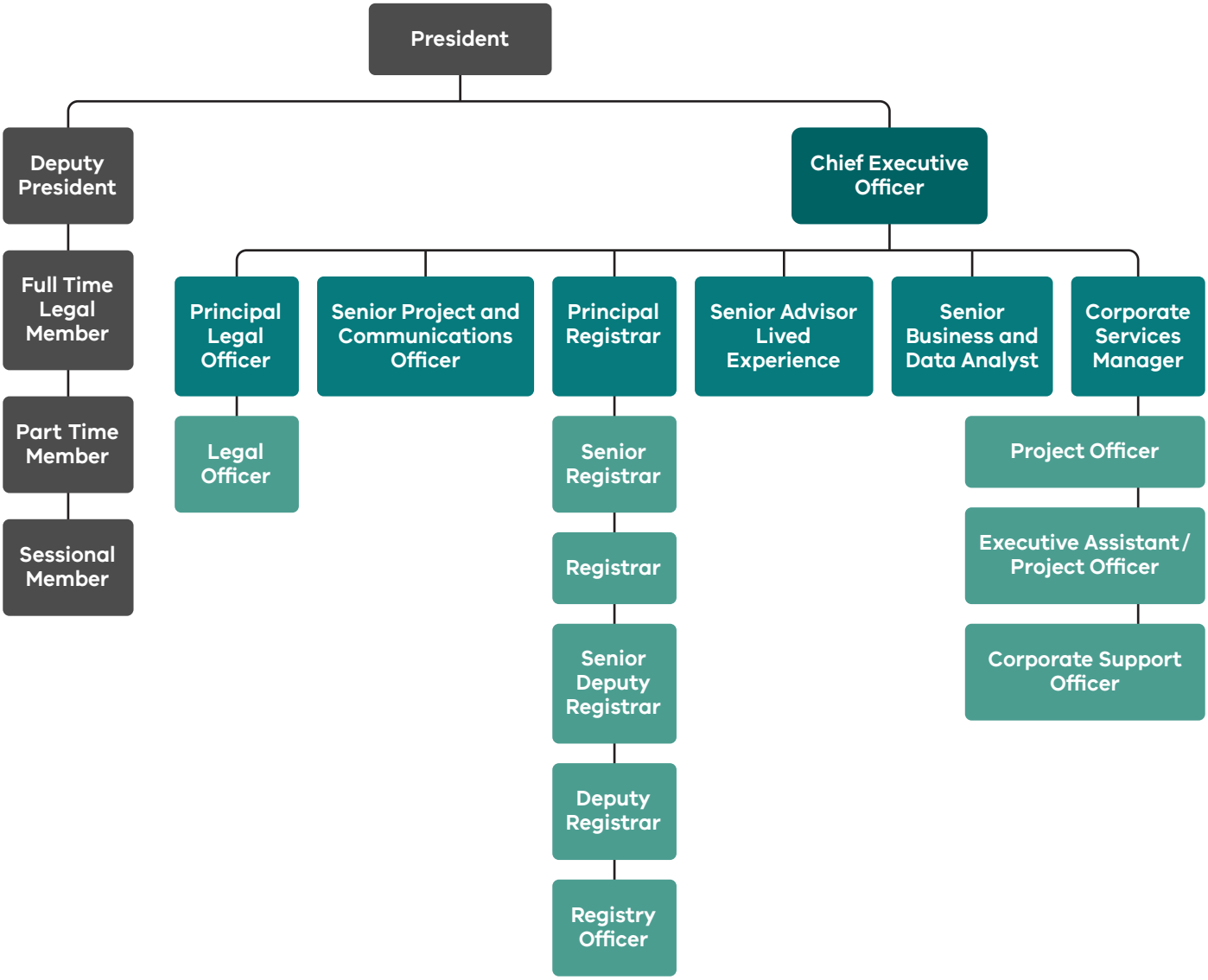
**Tribunal staff**

| | All employees | | Ongoing | | Fixed term/seconded | |
|---|---|---|---|---|---|---|
| | Headcount | Filled FTE | Headcount | Filled FTE | Headcount | Filled FTE |
| **Gender** | | | | | | |
| Female | 30 | 26.4 | 24 | 21 | 6 | 5.4 |
| Male | 7 | 6.1 | 5 | 4.7 | 2 | 1.4 |
| Non-binary and undisclosed | – | – | – | – | – | – |
| **Classification** | | | | | | |
| VPS 2 | 6 | 5 | 3 | 3 | 3 | 2 |
| VPS 3 | 10 | 9.2 | 9 | 8.2 | 1 | 1 |
| VPS 4 | 8 | 7 | 6 | 5 | 2 | 2 |
| VPS 5 | 8 | 7.1 | 7 | 6.3 | 1 | 0.8 |
| VPS 6 | 4 | 3.2 | 4 | 3.2 | – | – |
| Executive | 1 | 1 | – | – | 1 | 1 |
| **Total** | 37 | 32.5 | 29 | 25.7 | 8 | 6.8 |

**Tribunal members**

| | Full time and part time members | | Sessional members | |
|---|---|---|---|---|
| | Headcount | Filled FTE | Headcount | Filled FTE |
| **Gender** | | | | |
| Female | 4 | 3.2 | 74 | n/a |
| Male | 5 | 2.8 | 47 | n/a |
| Non-binary and undisclosed | – | – | – | – |
| **Category** | | | | |
| Community | 3 | 1.6 | 35 | n/a |
| Legal | 4 | 3.6 | 32 | n/a |
| Psychiatrist | 2 | 0.8 | 43 | n/a |
| Registered Medical | – | – | 11 | n/a |
| **Total** | 9 | 6 | 121 | – |

# Appendix C: Organisational Chart



# Appendix D: Membership list at 30 June 2025

The composition of the Tribunal includes 78 female and 52 male members, made up of three full-time members (the President, Deputy President and Senior Legal Member), six part-time members and 121 sessional members across all categories (legal, psychiatrist, registered medical practitioner and community).

| **Full time members** | Total period of appointment |
|---|---|
| **President** | |
| Mr Matthew Carroll | 1 June 2003 - 1 June 2028 |
| *Appointed to current position 23 May 2010* | |
| **Deputy President** | |
| Ms Emma Montgomery | 25 Aug 2014 - 9 June 2028 |
| *Appointed to current position 10 June 2023* | |
| **Senior Legal Member** | |
| Ms Camille Woodward | 10 June 2023 - 9 June 2028 |
| *Appointed to current position 10 June 2023* | |

| **Part-time Members** | Total period of appointment |
|---|---|
| **Legal Member** | |
| Mr Robert Daly | 10 June 2013 - 9 June 2028 |
| *Appointed to current position 15 September 2020* | |
| **Psychiatrist Member** | |
| Dr Michael McCausland | 10 June 2018 - 9 June 2028 |
| *Appointed to current position 15 September 2020* | |
| **Psychiatrist Member** | |
| Dr Philip Price | 10 June 2018 - 9 June 2028 |
| *Appointed to current position 10 June 2023* | |
| **Community Member** | |
| Mr Ashley Dickinson | 25 Feb 2011 - 1 Sept 2025 |
| *Appointed to current position 1 June 2014* | |
| **Community Member** | |
| Dr Kylie McShane | 29 June 1999 - 9 June 2028 |
| *Appointed to current position 10 June 2023* | |
| **Community Member** | |
| Ms Helen Walters | 10 June 2013 - 9 June 2028 |
| *Appointed to current position 1 June 2014* | |

| **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 Troy Barty | 1 June 2003 - 9 June 2028 |
| Ms Wendy Boddison | 7 Sept 2004 - 9 June 2028 |
| Ms Venetia Bombas | 10 June 2013 - 9 June 2028 |
| Ms Melissa Bray | 25 Feb 2021 - 1 Sept 2025 |
| Ms Jodie Burns | 10 June 2023 - 9 June 2028 |
| Mr Jeremy Cass | 25 Feb 2021 - 1 Sept 2025 |
| Ms Catherine Clarke | 17 Dec 2024 - 1 Sept 2025 |
| Mr Peter Cutting | 10 June 2023 - 9 June 2028 |
| Ms Arna Delle-Vergini | 10 June 2018 - 9 June 2028 |
| Ms Jennifer Ellis | 25 Feb 2016 - 1 Sept 2025 |
| Mr Brook Hely | 25 Feb 2011 - 1 Sept 2025 |
| Ms Amanda Hurst | 10 June 2013 - 9 June 2028 |
| Mr Gregory Levine | 10 June 2023 - 9 June 2028 |
| Ms Kim Magnussen | 25 Feb 2011 - 1 Sept 2025 |
| Ms Jo-Anne Mazzeo | 10 June 2013 - 9 June 2028 |
| Ms Robyn Mills | 10 June 2023 - 9 June 2028 |
| Mr Joel Orenstein | 17 Dec 2024 - 1 Sept 2025 |
| Ms Fotini Panagiotidis | 25 Feb 2021 - 1 Sept 2025 |
| Ms Penelope Ralston | 10 June 2023 - 9 June 2028 |
| Ms Kristen Rose | 17 Dec 2024 - 1 Sept 2025 |
| Ms Natalie Sheridan-Smith | 10 June 2023 - 9 June 2028 |
| Ms Helen Syme | 17 Dec 2024 - 1 Sept 2025 |
| Ms Sue Tait | 10 June 2013 - 9 June 2028 |
| Dr Michelle Taylor-Sands | 10 June 2013 - 9 June 2028 |
| 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 2028 |
| Dr Bethia Wilson | 10 June 2013 - 9 June 2028 |
| Ms Tania Wolff | 10 June 2018 - 9 June 2028 |
| Ms Magdalena Wysocka | 25 Feb 2021 - 1 Sept 2025 |

| Sessional members | Period of appointment |
|---|---|
| **Psychiatrist Members** | |
| 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 Abhilash Balakrishnan | 10 June 2023 - 9 June 2028 |
| Dr Anthony Barnes | 10 June 2018 - 9 June 2028 |
| Dr David Baron | 22 Jan 2003 - 1 Sept 2025 |
| Dr Ruth Borenstein | 10 June 2018 - 9 June 2028 |
| 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 2028 |
| Dr Sue Carey | 25 Feb 2011 - 1 Sept 2025 |
| Dr Robert Chazan | 25 Feb 2016 - 1 Sept 2025 |
| Dr Peter Churven | 10 June 2018 - 9 June 2028 |
| Dr Eamonn Cooke | 14 July 2009 - 9 June 2028 |
| Dr Blair Currie | 9 Oct 2012 - 1 Sept 2025 |
| Dr Stanley Gold | 10 June 2008 - 9 June 2028 |
| Dr Fintan Harte | 13 Feb 2007 - 1 Sept 2025 |
| Dr Harold Hecht | 9 Oct 2012 - 1 Sept 2025 |
| Dr Graham Hocking | 10 June 2023 - 9 June 2028 |
| Dr Jill Hosking | 10 June 2023 - 9 June 2028 |
| Dr Spiridoula Katsenos | 9 Oct 2012 - 1 Sept 2025 |
| Dr Diana Korevaar | 25 Feb 2021 - 1 Sept 2025 |
| Dr Jenny Lawrence | 9 Oct 2012 - 1 Sept 2025 |
| Dr Melissa Lowe | 10 June 2023 - 9 June 2028 |
| Dr Barbara Matheson | 9 Oct 2012 - 1 Sept 2025 |
| Dr Kristine Mercuri | 10 June 2023 - 9 June 2028 |
| Dr Peter Millington | 30 Oct 2001 - 9 June 2028 |
| Dr Ilana Nayman | 9 Oct 2012 - 1 Sept 2025 |
| Prof Daniel O'Connor | 27 June 2010 - 1 Sept 2025 |
| Dr Philip Roy | 9 Oct 2012 - 1 Sept 2025 |
| Dr Amanda Rynie | 25 Feb 2016 - 1 Sept 2025 |
| Dr Joanna Selman | 11 March 2014 - 9 June 2028 |
| Dr Anthony Sheehan | 10 June 2008 - 9 June 2028 |
| Dr Robert Shields | 10 June 2018 - 9 June 2028 |
| Dr Kieran Sinnott | 10 June 2023 - 9 June 2028 |
| Dr Oladipo Sorungbe | 10 June 2023 - 9 June 2028 |
| Assoc Prof Dean Stevenson | 25 Feb 2021 - 1 Sept 2025 |
| Dr Jennifer Torr | 11 March 2014 - 9 June 2028 |
| Dr Maria Triglia | 25 Feb 2011 - 1 Sep 2025 |
| Dr Ruth Vine | 9 Oct 2012 - 1 Sept 2025 |
| Dr Sue Weigall | 10 June 2018 - 9 June 2028 |
| Dr Ria Zergiotis | 10 June 2023 - 9 June 2028 |
| Dr Nina Zimmerman | 10 June 2023 - 9 June 2028 |

| Sessional members | Period of appointment |
|---|---|
| **Registered Medical Practitioner Members** | |
| Dr Adeola Akadiri | 25 Feb 2021 - 1 Sept 2025 |
| Assoc Prof Anthony Cross | 10 June 2023 - 9 June 2028 |
| 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 2028 |
| Dr John Hodgson | 1 July 2014 - 9 June 2028 |
| Dr Marija Kirjanenko | 10 June 2023 - 9 June 2028 |
| Dr Helen McKenzie | 1 July 2014 - 9 June 2028 |
| Dr Sandra Neate | 25 Feb 2016 - 1 Sept 2025 |
| Dr Stathis Papaioannou | 1 July 2014 - 9 June 2028 |
| Dr Maxine Waycott | 10 June 2023 - 9 June 2028 |

| Sessional members | Period of appointment |
|---|---|
| **Community Members** | |
| Dr Nadja Berberovic | 25 Feb 2021 - 1 Sept 2025 |
| Dr Lisa Brophy | 10 June 2008 - 9 June 2028 |
| Dr Leslie Cannold | 10 June 2013 - 9 June 2028 |
| Ms Katrina Clarke | 10 June 2018 - 9 June 2028 |
| Mr Christian Cosma | 10 June 2023 - 9 June 2028 |
| Ms Paula Davey | 29 Oct2014 - 9 June 2028 |
| Ms Robyn Duff | 25 Feb 2011 - 1 Sept 2025 |
| Ms Angela Eeles | 10 June 2018 - 9 June 2028 |
| Dr Josh Fergeus | 25 Feb 2021 - 1 Sept 2025 |
| Mr Harry Gelber | 25 Feb 2021 - 1 Sept 2025 |
| Ms Katherine George | 10 June 2023 - 9 June 2028 |
| Mr John Griffin | 25 Feb 2011 - 1 Sept 2025 |
| Ms Renee Harrison | 10 June 2023 - 9 June 2028 |
| Ms Philippa Hemus | 25 Feb 2021 - 1 Sept 2025 |
| Mr Ben Ilsley | 10 June 2013 - 9 June 2028 |
| Ms Erandathie Jayakody | 10 June 2018 - 9 June 2028 |
| Mr Jie (George) Jiang | 25 Feb 2021 - 1 Sept 2025 |
| Mr John King | 1 June 2003 - 1 Sept 2025 |
| Ms Fiona Knapp | 10 June 2023 - 9 June 2028 |
| Ms Danielle Le Brocq | 10 June 2013 - 9 June 2028 |
| Mr John Leatherland | 25 Feb 2011 - 1 Sept 2025 |
| Ms Anne Mahon | 10 June 2013 - 9 June 2028 |
| Ms Sarah Muling | 25 Feb 2016 - 1 Sept 2025 |
| Mr Aroon Naidoo | 25 Feb 2016 - 1 Septr 2025 |
| Mr Jack Nalpantidis | 23 July 1996 - 1 Sept 2025 |
| Ms Linda Rainsford | 10 June 2013 - 9 June 2028 |
| Mr Graham Rodda | 10 June 2018 - 9 June 2028 |
| Ms Lynne Ruggiero | 10 June 2013 - 9 June 2028 |
| Ms Helen Steele | 25 Feb 2016 - 1 Sept 2025 |
| Ms Charlotte Stockwell | 10 June 2013 - 9 June 2028 |
| Ms Tracey Taylor | 10 June 2023 - 9 June 2028 |
| 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 2028 |
| Mr Kenton Winsley | 10 June 2023 - 9 June 2028 |

# Appendix E: Compliance reports

In 2024-25, 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 41 requests for access to documents. In 21 of the requests, the information that was the subject of the request was information that related to the applicant's hearings with either the Tribunal or the former Mental Health Review Board; accordingly, the Tribunal released the documents administratively. Two of the requests required a formal response. Thirteen of the requests were not proceeded with or were withdrawn, no documents were found in relation to four requests and one request was transferred to the treating mental health service. One request was the subject of a review by the Office of the Victorian Information Commissioner.

### *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
GPO Box 4057
Melbourne VIC 3001

Phone: (03) 9032 3200

email: mht@mht.vic.gov.au

The 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 2024-25 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:

Public Interest Disclosures Coordinator, Integrity, Prevention and Detection Unit

Department of Health

50 Lonsdale Street

Melbourne VIC 3000

Telephone: 1300 024 324

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

In person at IBAC's office:

North Tower, Level 1,

459 Collins Street, Melbourne VIC 3000

Telephone: 1300 735 135

Email: info@ibac.vic.gov.au

Online using IBAC's online complaint form: www.ibac.vic.gov.au/report

The 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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