Mental Health Tribunal

Annual Report 2025 2026

Mental Health Tribunal

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Mental Health Tribunal

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28 August 2026

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 2025 to 30 June 2026.

Yours sincerely



Matthew Carroll
President

PRESIDENT'S MESSAGE

The previous two years saw substantial growth, with hearings conducted increasing by 11% in 2023-24 and 17% in 2024-25. It is an enormous relief to not report a similar increase this year. While hearing numbers rose by a more typical 2% in 2025-26, demand still exceeded capacity and required us to make difficult decisions.

The Tribunal first developed a schedule of listing priorities in November 2024 when there were intermittent periods when it wasn't always possible to conduct all hearings. We reviewed this schedule in August 2025 when it was evident that the gap between demand and capacity was likely to be protracted.

We allocated the highest priority to applications concerning matters where immediate planning and decisions about treatment rely on the Tribunal finalising a hearing – such as applications relating to ECT.

We focused on the scheme of hearings in the *Mental Health and Wellbeing Act 2022* (the Act). That scheme allows compulsory treatment to extend beyond 28 days only if the Tribunal makes a treatment order. The scheme also requires independent review when a compulsory patient is subjected to more restrictive treatment (if a community treatment order is varied to an inpatient treatment order). These protections are guaranteed; no action by a compulsory patient is needed to initiate the process and strict statutory deadlines apply. Accordingly, these hearings were prioritised.

The Act also enshrines a mechanism for compulsory patients to initiate a reconsideration of their treatment order with an application to revoke. The Act does not limit the number of times a patient can make these applications, but the Tribunal has discretion over when an application is listed and finalised. This discretion must be exercised in accordance with the Tribunal's obligations as a public authority under the Charter of Human Rights and Responsibilities. In line with those obligations, when exercising that discretion, the Tribunal adopted an approach that weighs considerations about where a compulsory patient is being treated (in hospital or the community) and whether and how often the Tribunal has heard an application for revocation from a patient during their current episode of treatment.

Scheduling in accordance with this framework there were only nine matters that were unable to be heard by the Tribunal. While this number is small that does not reduce the impact on those affected. When a hearing cannot proceed it can create uncertainty and distress for a patient when they are already navigating challenging circumstances. We acknowledge the significance of this on those individuals. The small number of missed hearings also makes it especially vital that the Tribunal highlights the impact on patient applications to revoke. There were significant delays in scheduling these matters, and the delay was excessive for some consumers on community treatment orders. The Tribunal deeply regrets those delays and acknowledges the extraordinary patience and understanding of impacted individuals.

These difficulties arose because an unprecedented surge in hearings coincided with reduced member availability. In 2024–25, we addressed the limited availability of legal members with expedited and then regular appointments. This year, the limited availability of psychiatrist and registered medical members had an impact. At the conclusion of the member appointment round underway at the time of our last annual report, the Tribunal welcomed four new psychiatrist and two new registered medical members. However, a greater number of members were retiring. The Minister for Mental Health accordingly approved a further, targeted appointment round for psychiatrist and registered medical members which was a remarkable success.

> **In April 2026, the Tribunal welcomed an additional 13 psychiatrist members and seven registered medical members.**

In April 2026, the Tribunal welcomed an additional 13 psychiatrist members and seven registered medical members. This will enable the Tribunal to convene up to 11 divisions per day and, assuming no further spikes in hearing numbers occur, we anticipate being able to schedule hearings as required early in 2026-27. This will also enable us to list patient applications within two to four weeks of their lodgement and allow more flexibility in listing to accommodate requests by parties concerning scheduling.

The Tribunal has also been managing an ongoing and dramatic increase in requests for statements of reasons. Historically the number of requests was stable at an average of 225 per year before a dramatic increase over the last two years. In 2024–25 there were 436 requests, which increased this year to 514. These sharp rises create a significant challenge. When hearing lists routinely give rise to requests for reasons, finalisation of a daily list consumes more member capacity. There are also significant impacts for legal and corporate staff who provide technical and administrative support for the preparation and finalisation of reasons. In this context the Tribunal conducted a review of all aspects of the statement of reasons process. The review included the format for reasons, examining efficiency as well as accessibility and relevance for the consumer, who is the primary audience for reasons. The input of our lived experience advisory group was invaluable in this process, and work in relation to statements of reasons continues.

The passage of the *Mental Health Legislation Amendment Act 2025* was another key determinant of the Tribunal's priorities and focus. Amongst other things, this Act transfers responsibility for decisions about forensic leave under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1977* from the Forensic Leave Panel (Panel) to the Tribunal. The change will take effect from 1 September 2026.

In an introductory meeting of the Panel and Tribunal, the President of the Panel, Justice Rita Incerti, urged everyone working on the implementation of this reform to seize the opportunity to review and improve processes rather than replicate and continue current practices. The Tribunal is working closely with Forensicare (including their Lived Experience Leaders and networks), Forensic Disability Services, members of the Panel and other stakeholders to explore procedures to implement at commencement.

Final decisions about procedures were not made when this annual report was prepared, so next year's report will provide details. Of course, 1 September 2026 is a starting point and as new procedures are tested and our experience develops, we anticipate identifying further refinements. The Tribunal is also committed to developing a tailored process for hearings concerning leave applications by forensic residents. Developing these processes is not possible before the forensic leave functions transfer to the Tribunal in September, but we plan to undertake this work as soon as practicable.

In terms of progressing other elements of our Strategic Plan, there are two things to highlight. Underpinning the successful implementation of all four of the Tribunal's strategic priorities is our commitment to elevating lived experience and the voices of consumers and carers. We continued to implement the outcomes of our Valuing Lived Experience project (discussed more in Part 3 of this report) and in May 2026 the Tribunal conducted a member forum focused on lived and living experience. The forum began with an extraordinary presentation by Commissioner Maggie Toko of the Mental Health and Wellbeing Commission, who shared her story to demonstrate the impact of embedding lived experience leadership, especially in the context of implementing far-reaching systemic reforms. Another highlight was a panel of lived experience leaders who answered questions and responded to issues the Tribunal raised, and also asked us questions, which fostered invaluable discussion and reflection.

The Tribunal's Strategic Plan includes a commitment to work with representative bodies to implement practices to make hearings more culturally safe for Aboriginal and Torres Strait Islander consumers. The final report of the Yoorrook Justice Commission included recommendations relating to representation in Tribunal hearings and cultural safety. Part 3 of this annual report provides details of the systems developed to identify Aboriginal and Torres Strait Islander patients earlier to promote access to culturally safe advocacy and legal support from Independent Mental Health Advocacy (IMHA) and the Victorian Aboriginal Legal Service (VALS), and to undertake case management before hearings. We will work with VALS and IMHA in the second half of 2026 to plan a pilot of culturally safe hearing procedures in 2027.

This is another year that has placed significant demands on Tribunal staff and members, and all have continued to respond with professionalism, generosity and good will. Like any critical service provider, the work is relentless. There is always the next hearing to conduct, case to list, legal advice to settle, IT issue to resolve, phone call or email enquiry to respond to. Staff and members attend to all these tasks and routinely check in to support each other and regularly ask 'could we do this better?' Thank you all for your extraordinary effort and contribution.

Matthew Carroll
President

We continued to implement the outcomes of our Valuing Lived Experience project and in May 2026 the Tribunal conducted a member forum focused on lived and living experience.

Membership changes during 2025-26

After multiple successful appointment rounds throughout 2025 and 2026, we are pleased to welcome the following members to the Tribunal:

Community Members

Ms Daisy Beyer
Dr Brianna Chesser
Ms Tamara Lobato
Ms Marie Piu
Ms Alexa Powell
Dr Cheryl Reed
Ms Helen Turley

Legal Members

Mr David Fanning
Ms Eleanore Fritze
Mr Philip Grano
Mr Marcus Ibaceta
Ms Laura McDonough
Ms Lisa Smith
Ms Katie Valentine
Ms Jade Werkmeister
Ms Renee Wilson
Ms Kate Windmill

Psychiatrist Members

Prof Marie Bismark
Dr Carrie Cheng
Dr Brett Coulson
Dr Rupak Dasgupta
Dr Beatrice Dowsett
Dr Melanie Jones
Dr Linda Kader
Dr Harsha Kadiveti
Dr Simone Keogh
Dr Anthony Miach
Dr Emily Moriarty
Assoc Prof Paul Robertson
Dr Bharathram Sathur Raghuraman
Dr Rodney Smith
Dr Katherine Tan
Assoc Prof Roth Trisno
Dr Graham Vessey

Registered Medical Members

Dr Hisham Almohandes
Dr Manu Bhatnagar
Dr James Fordyce
Dr Victoria Ho
Dr Claire Kembrey
Dr Kate Maxfield
Dr Shannon Price
Dr Nicole van der Nagel
Dr Jo-Anne Zappia

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

Community Members

Ms Robyn Duff
Mr Harry Gelber
Mr Jie (George) Jiang
Ms Zara Van Twest Smith
Dr Penny Webster

Legal Members

Mr Matthew Anstee
Ms Venetia Bombas
Ms Catherine Clarke
Ms Amanda Hurst
Ms Kim Magnussen
Ms Fotini Panagiotidis
Ms Helen Syme

Psychiatrist Members

Dr George Antony
Dr Daniel Brass
Dr Blair Currie
Dr Stanley Gold
Dr Harold Hecht
Dr Diana Korevaar
Dr Jenny Lawrence
Dr Philip Roy
Dr Sue Weigall

Registered Medical Members

Prof Charles Guest
Dr Sandra Neate

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 *Mental Health and Wellbeing Act 2022* 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.

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.

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

Access to documents and the serious harm test

The *Mental Health and Wellbeing Act 2022* generally entitles people to access documents connected to their Tribunal hearing before it takes place. This supports a person's ability to participate effectively in the hearing, which is an important aspect of procedural fairness. The Act permits the denial of access to documents only where the Tribunal is satisfied that disclosure may cause serious harm to the patient or another person.

In CZZ [2024] VMHT 030, the treating psychiatrist applied to withhold information contained in parts of the patient's clinical file. The treating team submitted that disclosure of the information may cause serious harm to the patient or another person. Because the application concerned information the treating team sought to withhold, CZZ did not attend that part of the hearing. However, a lawyer represented them who made submissions on their behalf.

In determining the application, the Tribunal carefully considered whether disclosure of the information may cause serious harm to the patient or another person in the particular circumstances of the case. The Tribunal also gave specific consideration to the patient's rights under the *Charter of Human Rights and Responsibilities Act 2006*, recognising that denying access to documents would limit the patient's right to a fair hearing.

The Tribunal questioned the treating team about the potential consequences of disclosure and closely reviewed the material sought to be withheld. Consistent with the limited nature of the exception, the Tribunal tested whether the application was confined only to those documents, and where possible only those parts of documents, containing information the treating team said created a risk of serious harm.

After considering the evidence, the Tribunal was satisfied that disclosure of the information may cause serious harm to CZZ or another person and granted the application. The Tribunal emphasised the importance of preventing the identified harm while minimising the impact on CZZ's rights. The Tribunal noted the information most relevant to the substantive hearing was contained in a report provided to CZZ, ensuring they had access to the key material the Tribunal would rely on when determining the treatment order application.

This case highlights the Tribunal's approach when exercising its power to deny access to documents. Access to information is an important safeguard that supports participation in Tribunal proceedings, so any restriction must be evidence-based, limited to what is necessary to prevent serious harm, and informed by the person's Charter rights.

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 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: www.austlii.edu.au.

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 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 that links to the AustLII website.

1.3.7 Rules and Practice Notes

The Tribunal has Rules governing essential aspects of its operation, accompanied by 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.

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 C, and a full list of members is available at Appendix D.

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 individual 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.

A pilot for the Tribunal craft project, a member led professional development program, was completed in September 2025 and the series formally rolled out in 2025-26.

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 (see Part Three).

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 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. The TWG meet quarterly.

During 2025-26, the TWG has worked together to:

- implement new scheduling priorities and manage the impacts to hearings
- manage reduced hearing capacity over the Christmas and New Year period
- learn more about the Mental Health Legal Rights Service helpline
- survey the TWG members about reviewing the TWG Terms of Reference
- manage the hearing schedule to reduce long hearing days
- implement new case management processes to improve cultural safety for Aboriginal and Torres Strait Islander patients
- develop the Tribunal's August 2026 – July 2027 Venue Calendar.

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.

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
- Language Loop

1.5.2 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.

CASE STUDY

Less restrictive means: when can treatment occur on a voluntary basis?

Section 143(d) of the *Mental Health and Wellbeing Act 2022* requires the Tribunal to be satisfied there are no less restrictive means reasonably available to enable a person to receive the immediate treatment they need. This criterion requires the Tribunal to consider whether treatment can occur on a voluntary basis or whether a compulsory treatment order is necessary.

The inquiry is evaluative rather than purely factual. For example, the Tribunal cannot rely just on a person's stated willingness to engage in treatment to be satisfied of this criterion. Instead, it must identify whether a less restrictive approach is reasonably available and assess if that approach is capable of meeting the person's immediate treatment needs. The Tribunal may consider matters such as the person's current treatment needs, their history of engagement with treatment and supports, and the risks associated with relying on alternative treatment arrangements. These factors do not automatically determine the criterion but assist the Tribunal in deciding whether the proposed arrangements are practically sufficient to meet the person's immediate treatment needs.

The Tribunal must also give proper consideration to the mental health and wellbeing principles, including dignity and autonomy, supported decision making, dignity of risk, and the principle that mental health and wellbeing services are to be provided with the least possible restriction of the person's rights, dignity and autonomy, and the aim of promoting their recovery and full participation in community life.

In TBN [2026] VMHT 24, the Tribunal was not satisfied that voluntary treatment was a reasonably available alternative.

TBN wished to cease medication due to significant side effects and expressed a clear preference not to engage with the treating team if made a voluntary patient. TBN identified a range of supports, including a general practitioner, a psychologist, an NDIS support worker and family members. The Tribunal examined whether these supports would in practice ensure that immediate treatment would continue.

The Tribunal accepted that TBN had been stable for an extended period but also identified features that in the context of TBN's circumstances, undermined the reliability of the proposed alternative treatment arrangements and their capacity to ensure that treatment would in fact occur. TBN had a limited understanding of the early signs their mental health was deteriorating, was unable to clearly describe previous relapses, and had only recently commenced with a new psychologist. Contact with other supports including their GP and NDIS support worker was infrequent and there was evidence that engagement might reduce.

Critically, TBN stated they would cease taking medication and disengage from the treating team if the order was revoked. The Tribunal considered that TBN's belief their mental illness had resolved demonstrated a limited understanding of the nature of their illness and the ongoing need for treatment. In reaching its decision, the Tribunal also had regard to TBN's history of relapse when unmedicated, the absence of a developed relapse prevention plan, and the limited capacity of existing supports to identify and respond to any deterioration in their mental health.

The Tribunal concluded that what TBN was proposing as a voluntary approach to treatment was not a reliable approach to meeting their immediate treatment needs.

In contrast, in VBZ [2026] VMHT 31, the Tribunal found that treatment could occur on a voluntary basis and revoked the treatment order.

VBZ was in the early stages of recovery and her treating team remained concerned about the risk of her mental health deteriorating as she transitioned from the structured and supportive environment of the Prevention and Recovery Care Unit (PARC) back to her home. The treating team considered that ongoing compulsory treatment would enable closer monitoring and allow a quick response if signs of relapse emerged.

While VBZ continued to experience some symptoms and disagreed with her treating team's rationale for her medication, she acknowledged the medication was helping and indicated she did not intend to change her current treatment. She found the support of her treating team beneficial and intended to remain in contact after her discharge from PARC.

While the treating team considered that ongoing compulsory treatment was necessary to support VBZ during her transition from PARC to the community and to enable a timely response to any deterioration in her mental health, the Tribunal was not persuaded these concerns made ongoing compulsory treatment necessary. Instead, it found that VBZ's long history of receiving treatment on a voluntary basis, her intention to continue with her current treatment, and her willingness to remain in contact with her treating team supported the conclusion she could receive immediate treatment on a voluntary basis. The Tribunal also noted the assessment and temporary treatment order process could, if necessary and the relevant criteria were met, be used to address future concerns about VBZ's mental health.

Having regard to the principles of dignity and autonomy, least restriction and dignity of risk, the Tribunal was satisfied that VBZ could receive immediate treatment on a voluntary basis and that a treatment order was not necessary.

These decisions show that section 143(d) of the Act is about whether a person's immediate treatment needs can be met without a treatment order.

The stated intention of TBN to disengage from treatment, limited understanding of the nature of their illness and need for treatment, and underdeveloped support arrangements meant voluntary treatment was not possible.

In contrast, the long history of VBZ receiving treatment on a voluntary basis, her intention to continue with her current treatment, and her willingness to remain in contact with her treating team supported the conclusion that treatment could occur voluntarily.

Priority Listing Strategy

In 2025-26, the Tribunal continued to experience unprecedented demand for hearings. Previously, the Tribunal needed to manage discreet periods of time when demand for hearings exceeded capacity. However, in 2025-26 the Tribunal experienced a sustained gap between capacity and demand, which impacted its ability to conduct all hearings required under the Act.

As part of its response, the Tribunal undertook a further review of the priority listing strategy that is used to determine the order in which matters will be listed. This review was also informed by the Tribunal's obligations as a public authority under the *Charter of Human Rights and Responsibilities* (the Charter).

From September 2025, these revised scheduling priorities were put into effect:

Priority 1
Applications for electroconvulsive treatment (ECT), neurosurgery for mental illness (NMI) and applications relating to interstate transfers and against transfers between designated mental health services (DMHS).

Priority 2
28-day temporary treatment order and secure treatment order hearings (including any concurrent patient application to revoke the order).

Priority 3
Applications for a treatment order and six-month secure treatment order hearings (including any concurrent patient application to revoke the order).

Priority 4
Hearings regarding a variation of a treatment order from a community to an inpatient setting (including any concurrent patient application to revoke the order).

Priority 5
A compulsory patient's first application to revoke an inpatient treatment order.

Priority 6
A compulsory patient's first application to revoke a community treatment order.

Priority 7
Subsequent patient applications to revoke a treatment order.

The rationale for this approach is explained in the President's message.

What did this mean for hearings and consumers?

There were times the Tribunal was not able to schedule or conduct all hearings required. When this happened, the Tribunal wrote to the consumer, their nominated support person or carer, the consumer's treating team and their legal representative to advise them.

Some hearings were delayed, including variation hearings and patient applications to revoke. The most notable impact was to applications to revoke where average wait times were up to eight weeks, with the longest wait time being 20 weeks.

While it is usual practice for the Tribunal to have pending matters (i.e. matters scheduled to a specific date and waiting to be heard), this marked the first instance of a backlog (matters unable to be scheduled). A consequence of this is that the number of hearings conducted in 2025-26 is not a full measure of hearings required, or the demand for hearings. The size of the backlog changed constantly as a consequence of matters being listed as soon as there was room on a hearing list, but this being offset by new applications being lodged. It is estimated that if the Tribunal had been able to list and conduct all matters (as it has done previously) the total number of hearings conducted in 2025-26 would be approximately 13,600.

Increasing capacity to meet demand

To address capacity needs, in 2025-26 the Tribunal undertook additional member recruitment with the support of the Department of Health. Pleasingly there have been 43 additional members appointed, many of whom commenced sitting in May and June, and remainder of whom commence sitting from August 2026.

With the increase in members the Tribunal will be able to schedule an additional 14 divisions per fortnight from August 2026, which will be sufficient to meet demand, including forensic leave hearings from September 2026, and allow for greater flexibility in scheduling to better meet the preferences of patients, carers and treating teams.

PART TWO
HEARING STATISTICS FOR 2025-26

Key statistics at a glance*

	2025-26	2024-25^	2023-24^
Hearings listed§	18,477	17,735	15,775
Hearings conducted	13,274	13,029	11,129
Hearings determined	11,414	11,144	9,398
Hearings adjourned#	1,860	1,885	1,731
Number of patients who had a hearing‡	6,468	6,171	5,618

	2025-26	2024-25	2023-24^
Treatment orders made / confirmed	10,120	10,087	8,350
Temporary treatment orders / Treatment orders revoked	829	633	617
ECT orders made	623	663	507
ECT applications refused	117	90	77
NMI hearings conducted	4	5	4
Statement of reasons requested	514	436	348
Applications to VCAT	94	44	34

Attendance at hearings

	2025-26	2024-25	2023-24^
Patient	7,778	7,599	6,852
Carers and family members	2,605	2,534	2,387
Nominated support persons	362	340	267
Guardians	71	71	60
Medical treatment decision makers	36	44	27
Support persons	1,144	1,146	857
Interpreters	724	702	613
Legal representatives	2,520	2,148	1,902

* *The figures in Parts 2.1 to 2.9 and Parts 2.12 to 2.13 represent determinations at substantive hearings and exclude hearings that were adjourned or finalised without a determination.*

§ *There are more hearings listed than conducted because hearings may not proceed due to changes in a patient's circumstances. For example, a hearing may be listed for a patient but prior to the hearing date the patient's order is revoked, meaning the person is no longer a compulsory patient and they no longer required a hearing.*

^ *Figures for 2023-24 and 2024-25 may vary from figures published in previous Annual Reports due to improved reporting methodology.*

\# *A further 125 hearings were adjourned on the papers; they are not included in this count.*

‡ *This count excludes applications to deny access to documents.*

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

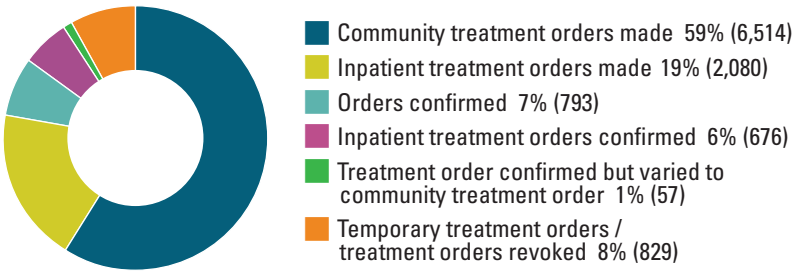
2.1.1 Outcomes of hearings regarding treatment orders (all case types)

In 2025-26, the Tribunal made a total of 8,594 treatment orders, confirmed 1,526 treatment orders and revoked 829 temporary treatment orders and treatment orders. There were eight matters where the Tribunal found it did not have jurisdiction to conduct a hearing and 123 applications were struck out. The most common reason for a strike out is where a patient has made an application for revocation and fails to appear at the hearing. When an application is struck out, the underlying treatment order or temporary treatment order is not affected and continues to operate; furthermore, a patient is able to make a further application if they wish to do so.

Table 1: Determinations regarding treatment orders

	2025-26	2024-25	2023-24
Community treatment orders made	**59% (6,514)**	57% (6,086)	54% (4,845)
Inpatient treatment orders made	**19% (2,080)**	21% (2,277)	24% (2,164)
Orders confirmed	**7% (793)**	9% (970)	—
Inpatient treatment orders confirmed	**6% (676)**	6% (694)	—
Treatment order confirmed but varied to community treatment order	**1% (57)**	1% (60)	—
Temporary treatment orders / treatment orders revoked	**8% (829)**	6% (633)	7% (617)
Total	**100% (10,949)**	100% (10,720)	100% (8,967)

Figure 1: Determinations regarding treatment orders in 2025-26



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

	2025-26	2024-25	2023-24
Community treatment orders made	**51% (2,053)**	49% (1,952)	45% (1,569)
Inpatient treatment orders made	**39% (1,574)**	44% (1,740)	47% (1,619)
Temporary treatment orders revoked	**10% (389)**	7% (280)	8% (276)
Total	**100% (4,016)**	100% (3,972)	100% (3,464)

Figure 2: Outcomes of 28-day hearings in 2025-26



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

	2025-26	2024-25	2023-24
1–11 weeks	**4% (83)**	4% (86)	7% (104)
12 weeks	**14% (279)**	14% (267)	14% (226)
13–25 weeks	**16% (324)**	14% (272)	15% (239)
26 weeks	**66% (1,367)**	68% (1,327)	62% (974)
27–51 weeks	**—**	—	< 1% (1)
52 weeks	**—**	—	2% (25)
Total	**100% (2,053)**	100% (1,952)	100% (1,569)

Figure 3: Duration of community treatment orders made in 28-day hearings in 2025-26

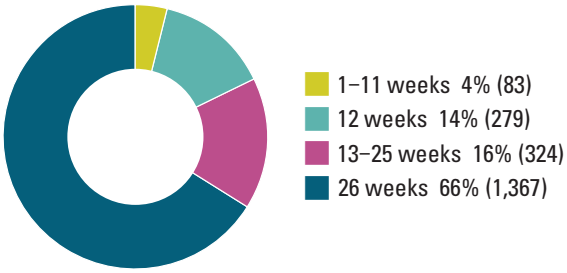
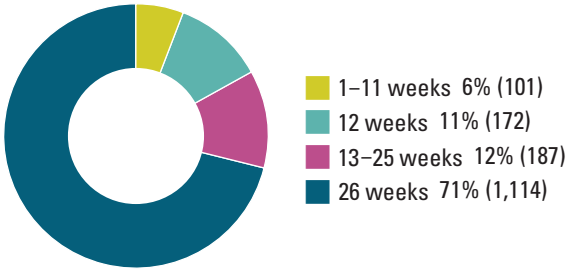


Table 4: Duration of inpatient treatment orders made in 28-day hearings

	2025-26	2024-25	2023-24
1–11 weeks	**6% (101)**	6% (103)	9% (145)
12 weeks	**11% (172)**	14% (234)	16% (258)
13–25 weeks	**12% (187)**	11% (197)	14% (231)
26 weeks	**71% (1,114)**	69% (1,206)	61% (985)
Total	**100% (1,574)**	100% (1,740)	100% (1,619)

Figure 4: Duration of inpatient treatment orders made in 28-day hearings in 2025-26



The Tribunal revokes a temporary treatment order when one or more of the criteria for treatment in s143 of the Act is not met. The reasons for revocation of a temporary treatment order were as follows:

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

	2025-26	2024-25	2023-24
The person did not have a mental illness	**4%**	3%	3%
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%**	5%	7%
Immediate treatment was not able to be provided	**9%**	11%	12%
Immediate treatment was able to be provided in a less restrictive manner	**83%**	81%	78%
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

	2025-26	2024-25	2023-24
Community treatment orders made	**85% (4,461)**	85% (4,134)	83% (3,216)
Inpatient treatment orders made	**10% (506)**	11% (537)	12% (452)
Treatment orders revoked	**5% (279)**	4% (198)	5% (204)
Total	**100% (5,246)**	100% (4,869)	100% (3,872)

Figure 5: Outcomes of authorised psychiatrist application hearings in 2025-26



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

	2025-26	2024-25	2023-24
1–11 weeks	**1% (32)**	1% (53)	2% (45)
12 weeks	**5% (203)**	6% (230)	6% (194)
13–25 weeks	**7% (328)**	7% (294)	6% (195)
26 weeks	**87% (3,898)**	86% (3,557)	81% (2,614)
27–51 weeks	**—**	—	< 1% (6)
52 weeks	**—**	—	5% (162)
Total	**100% (4,461)**	100% (4,134)	100% (3,216)

Figure 6: Duration of community treatment orders made in authorised psychiatrist application hearings in 2025-26

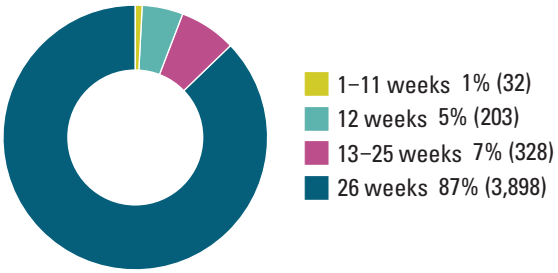
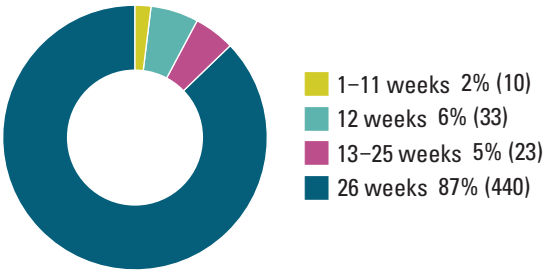


Table 8: Duration of inpatient treatment orders made in authorised psychiatrist application hearings

	2025-26	2024-25	2023-24
1–11 weeks	**2% (10)**	4% (20)	5% (20)
12 weeks	**6% (33)**	5% (29)	6% (29)
13–25 weeks	**5% (23)**	3% (17)	6% (26)
26 weeks	**87% (440)**	88% (471)	83% (377)
Total	**100% (506)**	100% (537)	100% (452)

Figure 7: Duration of inpatient treatment orders made in authorised psychiatrist application hearings in 2025-26



As with temporary treatment orders, the Tribunal revokes a treatment order when one or more of the criteria for treatment in s143 of the Act is not met. The reasons for revocation of the treatment order with respect to applications by the authorised psychiatrist were as follows:

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

	2025-26	2024-25	2023-24
The person did not have a mental illness	**2%**	3%	3%
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	**7%**	9%	6%
Immediate treatment was not able to be provided	**9%**	11%	13%
Immediate treatment was able to be provided in a less restrictive manner	**82%**	77%	78%
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

	2025-26	2024-25	2023-24
Community treatment orders made	—	—	3% (19)
Inpatient treatment orders made	—	—	12% (91)
Inpatient treatment orders confirmed	**87% (676)**	87% (694)	71% (530)
Treatment orders confirmed but varied to community treatment order	**7% (57)**	7% (60)	8% (58)
Treatment orders revoked	**6% (48)**	6% (45)	6% (44)
Total	**100% (781)**	100% (799)	100% (742)

Figure 8: Outcomes of variation hearings in 2025-26



The reasons for revocation of the treatment order in hearings triggered by variations were:

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

	2025-26	2024-25	2023-24
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	**0%**	4%	0%
Immediate treatment was not able to be provided	**83%**	85%	73%
Immediate treatment was able to be provided in a less restrictive manner	**17%**	11%	27%
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

	2025-26	2024-25	2023-24
Community treatment orders made	**—**	—	10% (94)
Inpatient treatment orders made	**—**	—	5% (53)
Orders confirmed	**88% (793)**	90% (970)	75% (753)
Temporary treatment orders or treatment orders revoked	**12% (113)**	10% (110)	10% (102)
Total	**100% (906)**	100% (1,080)	100% (1,002)

Figure 9: Outcomes of revocation hearings in 2025-26



The reasons for revoking a temporary treatment order or treatment order in proceedings initiated by the patient were as follows:

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

	2025-26	2024-25	2023-24
The person did not have a mental illness	**1%**	2%	3%
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	**12%**	9%	13%
Immediate treatment was not able to be provided	**4%**	8%	5%
Immediate treatment was able to be provided in a less restrictive manner	**83%**	81%	79%
Total	**100%**	100%	100%

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

CASE STUDY

Inpatient or community treatment

When the Tribunal makes or confirms a treatment order it must also determine the setting in which treatment is to be delivered. Section 194 of the *Mental Health and Wellbeing Act 2022* provides that the Tribunal must not make an inpatient treatment order unless it is satisfied the person cannot be treated in the community. This is a high threshold.

The decision in OKT [2026] VMHT 29 illustrates the care the Tribunal takes when scrutinising the reasons advanced for continued inpatient treatment. At the time of the hearing, OKT had been admitted to a secure extended care unit. The treating team recommended the inpatient treatment order be maintained, relying on a combination of concerns. This included OKT's mental state, the need to adjust his medication and the suitability of his accommodation. In contrast, OKT expressed a clear preference to return to the community. He described living in a caravan as a positive choice, identified a range of supports available to him outside hospital including NDIS involvement. Evidence from support persons indicated that OKT was engaging with those supports before his admission and had shown improvement in managing his behaviour, and that his circumstances had settled.

The Tribunal accepted the compulsory treatment criteria were met. The question was then whether the test for an inpatient order was established.

With respect to OKT's mental state, the Tribunal noted that while the treating team had concerns about agitation and potential aggression, the most recent evidence indicated his presentation had improved in the period leading up to the hearing. Critically, OKT had previously lived in the community while experiencing symptoms. This meant the evidence did not clearly establish that his current mental state made community treatment impossible.

The treating team preferred more stable housing for OKT but also accepted he could receive treatment while living in his caravan. While the Tribunal often accepts that lack of accommodation means it isn't possible for a person to receive treatment in the community, the evidence demonstrated that while OKT's accommodation was not ideal it appeared to work for him and provided a base for him to receive community treatment, particularly given that further supports could be arranged.

With respect to medication adjustment, the treating team said that hospital was the preferable setting for stabilising OKT's health and expressed concern about his ability to engage in treatment in the community. The Tribunal did not accept that these factors prevented OKT from receiving treatment in the community. The Tribunal decided that OKT could be supported through a community treatment order and existing supports, including NDIS involvement. It found no persuasive evidence that medication changes could not be safely managed in the community.

The Tribunal varied OKT's order to a community treatment order.

2.3 ECT order applications related to adults

2.3.1 Outcomes of applications for an ECT order

In 2025-26, the Tribunal made decisions about 727 applications for an electroconvulsive treatment (ECT) order for an adult. ECT orders were made in 549 hearings for adult patients and 115 applications were refused. ECT orders were made in 61 hearings for adults being treated as voluntary patients and 2 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

	2025-26	2024-25	2023-24
ECT orders made			
Adult patients	**549**	589	440
Adults not a patient	**61**	69	64
ECT applications refused			
Adult patients	**115**	88	74
Adults not a patient	**2**	2	3
Total	**727**	748	581

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.

Table 15: Determinations regarding applications for an ECT order

	2025-26	2024-25	2023-24
ECT orders made	**84% (610)**	88% (658)	87% (504)
ECT applications refused	**16% (117)**	12% (90)	13% (77)
Total	**100% (727)**	100% (748)	100% (581)

Figure 10: Determinations regarding applications for an ECT order in 2025-26

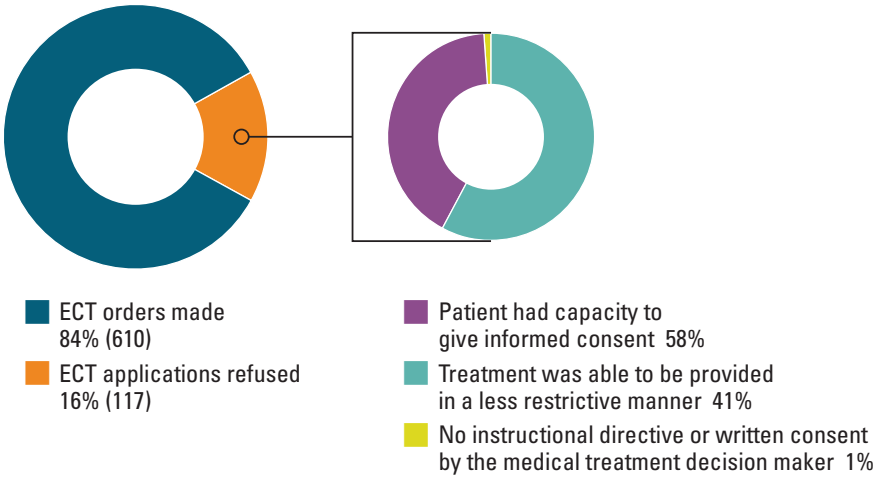


Table 16: Duration of ECT orders made

	2025-26	2024-25	2023-24
1–11 weeks	**22% (132)**	34% (223)	45% (225)
12 weeks	**31% (189)**	24% (159)	17% (85)
13–25 weeks	**5% (34)**	7% (44)	6% (33)
26 weeks	**42% (255)**	35% (232)	32% (161)
Total	**100% (610)**	100% (658)	100% (504)

Figure 11: Duration of ECT orders made in 2025-26

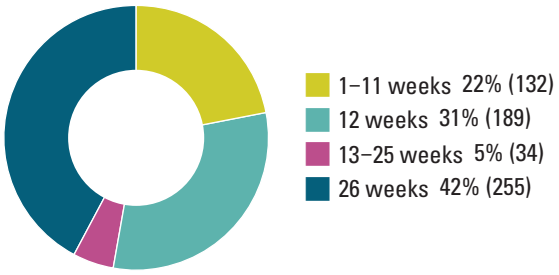


Table 17: Number of ECT treatments authorised

	2025-26	2024-25	2023-24
1–11 treatments	**3% (19)**	4% (25)	7% (34)
12 treatments	**97% (591)**	96% (633)	93% (470)
Total	**100% (610)**	100% (658)	100% (504)

Figure 12: Number of ECT treatments authorised in 2025-26

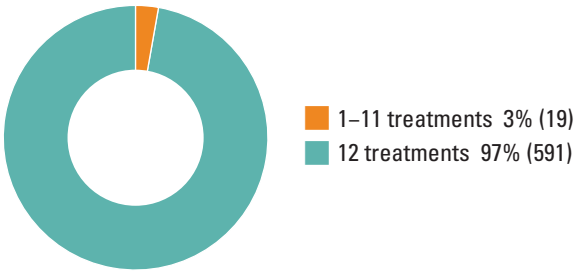


*Table 18: Reasons applications for an ECT order were refused**

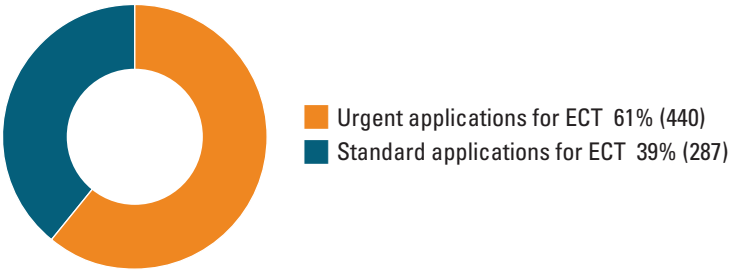
	2025-26	2024-25	2023-24
Patient had the capacity to give informed consent	**58%**	59%	54%
Treatment was able to be provided in a less restrictive manner	**41%**	41%	46%
No instructional directive or written consent by the medical treatment decision maker	**1%**	0%	0%
Total	**100%**	100%	100%

** 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

	2025-26	2024-25	2023-24
Urgent applications for ECT	**61% (440)**	62% (462)	62% (359)
Standard applications for ECT	**39% (287)**	38% (286)	38% (222)
Total	**100% (727)**	100% (748)	100% (581)

Figure 13: Proportion of applications for ECT orders which were urgent in 2025-26



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 2025-26 the Tribunal heard three urgent after-hours ECT applications. All ECT applications were granted.

2.3.3 Elapsed time from receipt of ECT applications to hearing

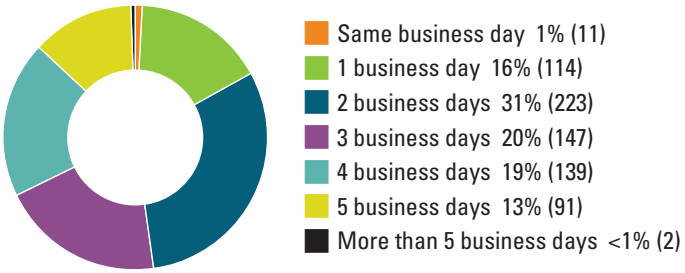
The Tribunal's Registry has detailed procedures that apply to the listing of ECT applications, including urgent applications. The Tribunal's listing processes consider patient participation in, and procedural fairness of, hearings, as well as the urgency of the application. Particular caution is taken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

Urgent applications are still handled expeditiously however, 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

	2025-26	2024-25	2023-24
Same business day	**1% (11)**	3% (24)	3% (19)
1 business day	**16% (114)**	23% (175)	21% (124)
2 business days	**31% (223)**	23% (174)	25% (145)
3 business days	**20% (147)**	21% (153)	19% (110)
4 business days	**19% (139)**	17% (129)	19% (108)
5 business days	**13% (91)**	13% (93)	12% (70)
More than 5 business days	**< 1% (2)**	0% (0)	1% (5)
Total	**100% (727)**	100% (748)	100% (581)

Figure 14: Elapsed time from receipt of ECT applications to hearing in 2025-26



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

Compulsory patients

During 2025-26, there were 12 applications received in relation to a compulsory patient under 18 years of age. All applications were granted.

Voluntary patients

The Tribunal also determines whether ECT can be performed on a voluntary patient under the age of 18. During 2025-26, the Tribunal received one application concerning a voluntary patient under 18 years old. That application was granted.

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

	2025-26	2024-25	2023-24
Compulsory patients - ECT orders made			
Patient's age: 14	**1**	0	0
Patient's age: 15	**1**	1	1
Patient's age: 16	**7**	0	0
Patient's age: 17	**3**	0	2
Voluntary patients - ECT orders made			
Patient's age: 13	**1**	0	0
Patient's age: 15	**0**	2	0
Total	**13**	3	3

2.5 Neurosurgery for mental illness

In 2025-26, the Tribunal received four applications to perform neurosurgery for mental illness (NMI). All applications were granted.

Table 22: Number and outcomes of applications to perform NMI in 2025-26

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

CASE STUDY

Testing the evidence relating to mental illness

Section 143(a) of the *Mental Health and Wellbeing Act 2022* requires the Tribunal to determine whether a person has a mental illness. The Act defines mental illness as a medical condition characterised by a significant disturbance of thought, mood, memory or perception. The Tribunal does not need to be satisfied of a specific diagnosis.

This criterion must be considered alongside section 4(2) of the Act, which provides that a person is not to be considered to have a mental illness by reason only of certain beliefs, behaviours or attributes. This includes holding particular religious, spiritual or cultural beliefs, engaging in illegal or antisocial conduct, experiencing psychological distress, or being a member of a particular cultural or racial group.

In WWQ [2026] VMHT 27, the Tribunal needed to carefully assess the distinction between cultural and spiritual beliefs, and symptoms of mental illness.

WWQ held longstanding spiritual beliefs embedded in her cultural background. She consistently rejected the suggestion she had a mental illness, describing herself as opposed to conventional medicine and grounded in a spiritual worldview. Her family also recognised these beliefs and the Tribunal accepted that many aspects of WWQ's belief system were longstanding and culturally informed. This was a critical starting point, given that section 4(2) prevents such beliefs from, of themselves, being the basis for concluding a person has a mental illness for the purposes of section 143(a). The mental health and wellbeing principles also requires that services are culturally safe and responsive to a person's background.

Approaching the evidence with caution, the Tribunal nevertheless identified features of WWQ's presentation that could be differentiated from her cultural beliefs. This included her expressing beliefs that while referring to God, were objectively demonstrated to be delusions. WWQ also expressed ideas about being targeted and referred to spiritual phenomena in a way the Tribunal found difficult to follow. The Tribunal found this reflected a disturbance in the organisation of her thinking.

As WWQ had been receiving treatment on a temporary treatment order, the Tribunal was able to consider the effect of treatment. After the commencement of antipsychotic medication, WWQ's core cultural and spiritual beliefs remained intact. However, her thinking became more organised, and she could engage meaningfully in complex discussions and exercise choice about her broader healthcare, including end of life care. This wasn't possible before WWQ commenced mental health treatment and supported the existence of a separate disturbance of thought attributable to mental illness.

The Tribunal's reasoning also considered the principle of dignity of risk. It recognised WWQ's right to make decisions about health treatment, including her decision not to pursue certain medical interventions based on her deeply held beliefs and values, and did not seek to characterise those choices as evidence of mental illness. Rather, the focus remained on whether mental illness affected either or both the form and content of WWQ's thinking.

UOS [2026] VMHT 18 raised a different but equally complex question of whether a person's behaviour and experiences could be explained by proven stressors and circumstances, rather than mental illness.

UOS strongly disputed he had a mental illness and provided a detailed alternative account of his experiences. He attributed past incidents and interactions including conflict with police, neighbourhood disputes, and legal issues to external factors such as workplace pressures, financial stress and interpersonal difficulties. The Tribunal acknowledged these stressors were real and that aspects of his presentation like frustration, conflict and dissatisfaction with authorities could not of themselves constitute mental illness under section 4(1) of the Act. Furthermore, under section 4(2), factors such as exhibiting psychological distress, involvement in family conflict or engaging in antisocial behaviour cannot alone establish the presence of a mental illness. A further consideration was that during a brief hospital admission the treating team did not observe active symptoms of psychosis. UOS relied on this as evidence that no mental illness was present.

Having considered the evidence, the Tribunal was persuaded that UOS experienced disturbances of thought and mood not attributable to stress or frustration linked to external pressures, or personality traits alone. It placed particular weight on clinical records and what it saw as a recurring pattern of paranoid thinking and disordered thought processes. In analysing an incident involving a serious altercation with police, the Tribunal accepted that while UOS attributed his actions to the conduct of the police, symptoms of paranoia and disordered thinking were present in the lead up to and had a central role in the event. Regarding the hospital admission of UOS, the Tribunal accepted he was not exhibiting symptoms but accepted the treating team's explanation that the absence of acute symptoms at that time was attributable to recent treatment, rather than the absence of a mental illness.

While the Tribunal ultimately found that mental illness was present, the Tribunal engaged directly with UOS's account examining the explanations he offered for his behaviour alongside the clinical material. While it did not accept UOS's explanation, this hearing demonstrates the Tribunal's role in weighing competing accounts of a person's experiences and ensuring the patient's explanation is given careful consideration and only displaced by robust evidence supporting the presence of a mental illness.

2.6 Security patients

During 2025-26, the Tribunal made 111 determinations in relation to security patients. The types of hearings and outcomes are detailed below.

Table 23: Determinations made in relation to security patients

	2025-26	2024-25	2023-24
28-day review			
Remain a security patient	**100**	76	88
Discharge as security patient	**8**	4	3
6-month review			
Remain a security patient	**1**	0	0
Discharge as security patient	**0**	0	0
Application for revocation by the patient			
Remain a security patient	**1**	2	2
Discharge as security patient	**1**	1	3
Application by a security patient regarding leave			
Application granted	**0**	0	0
Application refused	**0**	0	0
Total	**111**	83	96

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

During 2025-26, the Tribunal received eight 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

	2025-26	2024-25	2023-24
Directed to remain subject to order as varied	**7**	4	8
Directed treatment by original treating service	**1**	0	3
Total	**8**	4	11

2.8 Applications to transfer a person interstate

During 2025-26, the Tribunal received two applications to transfer a person interstate.

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

	2025-26	2024-25	2023-24
Applications granted	**2**	2	1
Applications refused	**0**	0	0
Total	**2**	2	1

2.9 Applications to transfer responsibility for treatment interstate

During 2025-26, the Tribunal received one application to transfer responsibility for treatment interstate.

Table 26: Determinations made in relation to applications to transfer responsibility for treatment interstate

	2025-26	2024-25	2023-24
Applications granted	**0**	0	0
Applications refused	**1**	0	0
Total	**1**	0	0

2.10 Applications to deny access to documents

During 2025-26, the Tribunal received 271 applications to deny access to documents.

Table 27: Determinations made in relation to applications to deny access to documents

	2025-26	2024-25	2023-24
Applications granted	**245**	242	192
Applications refused	**26**	22	13
Total	**271**	264	205

2.11 Applications for review by VCAT

In 2025-26, 94 applications were made to VCAT for a review of a Tribunal decision.

Table 28: Applications to VCAT and their status

	2025-26	2024-25	2023-24
Applications made – treatment order	**83**	31	Not available
Applications made – ECT order	**11**	13	Not available
Applications made – total	**94**	44	34
Applications withdrawn	**19**	18	12
Applications struck out	**8**	0	0
Applications dismissed	**12**	2	4
Hearings vacated	**2**	1	1
Decision set aside by consent	**3**	0	0
No jurisdiction	**2**	0	1
Applications proceeded to full hearing and determination	**36**	21	11
Applications pending at 30 June	**12**	2	5

Table 29: Outcomes of applications determined by VCAT

	2025-26	2024-25	2023-24
Decisions affirmed	**25**	18	9
Decisions varied	**1**	1	0
Decisions set aside and another decision made in substitution	**0**	4	2
Orders revoked	**15**	1	0
Other (Cases withdrawn, dismissed, vacated or pending)	**53**	20	23
Total	**94**	44	34

2.12 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.

In 2025-26, there were 125 hearings that were adjourned on the papers. 122 hearings were adjourned on the papers because the Tribunal was unable to constitute a division, and 3 were adjourned on the papers because there was no capacity to conduct a hearing. These adjournments are not included in this section.

Table 30: Hearings adjourned

	2025-26	2024-25	2023-24
Hearings adjourned without extending the order	**14% (260)**	18% (332)	17% (302)
Hearings adjourned with order extended	**86% (1,600)**	82% (1,553)	83% (1,429)
Total	**100% (1,860)**	100% (1,885)	100% (1,731)
Hearings adjourned as a percentage of total hearings conducted	**14%**	14%	16%

Figure 15: Hearings adjourned in 2025-26

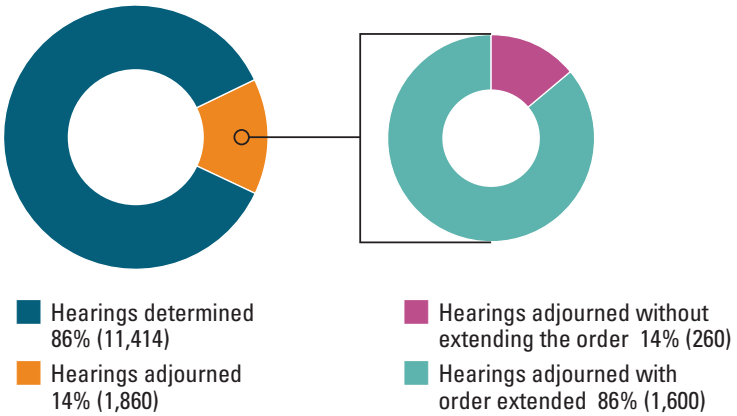
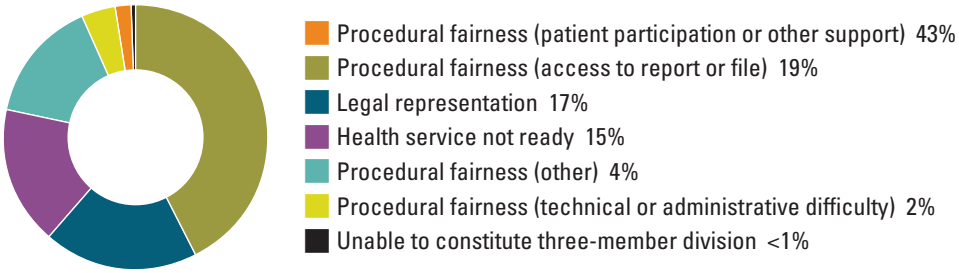


Table 31: Reasons for adjournment with extension of order

	2025-26	2024-25	2023-24
Procedural fairness (patient participation or other support)	**43%**	43%	42%
Procedural fairness (access to report or file)	**19%**	18%	19%
Legal representation	**17%**	16%	19%
Health service not ready	**15%**	15%	14%
Procedural fairness (other)	**4%**	6%	6%
Procedural fairness (technical or administrative difficulty)	**2%**	-	-
Unable to constitute three-member division	**< 1%**	2%	< 1%
Total	**100%**	100%	100%

Figure 16: Reasons for adjournment with extension of order in 2025-26



2.13 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 2025-26, there were no hearings conducted by a single member division of the Tribunal.

2.14 Attendance and legal representation at hearings

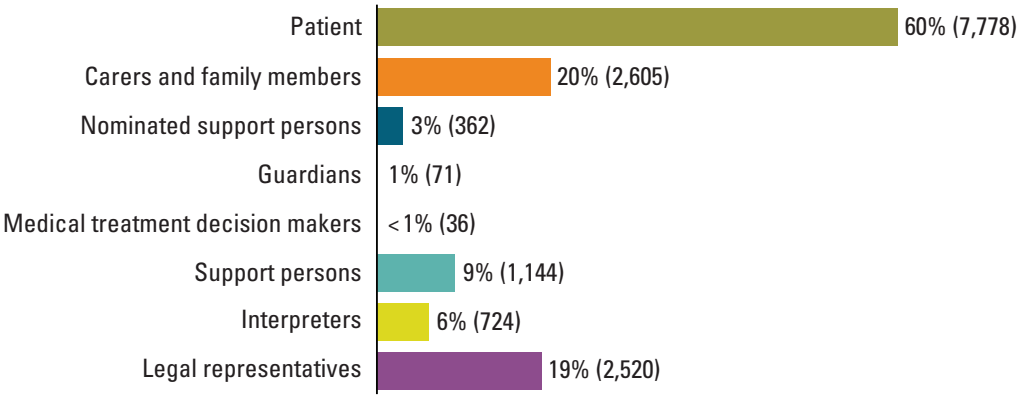
2.14.1 Attendance at hearings

Part Three of the Annual Report highlights the Tribunal's commitment to promoting the participation in hearings of patients and the people who support them. The Tribunal strongly encourages the attendance of patients and those who support them at all hearings.

Table 32: Number and percentage of hearings with patients and support persons in attendance

	2025-26	2024-25	2023-24
Patient	**60% (7,778)**	60% (7,599)	63% (6,852)
Carers, family members and parents	**20% (2,605)**	20% (2,534)	22% (2,687)
Nominated support persons	**3% (362)**	3% (340)	2% (267)
Guardians	**1% (71)**	1% (71)	1% (60)
Medical treatment decision makers	**< 1% (36)**	< 1% (44)	< 1% (27)
Support persons	**9% (1,144)**	9% (1,146)	8% (857)
Interpreters	**6% (724)**	6% (702)	6% (613)
Legal representatives	**19% (2,520)**	16% (2,148)	17% (1,903)

Figure 17: Number and percentage of hearings with patients and support persons in attendance in 2025-26



2.14.2 Legal representation at hearings

As noted in Part One, legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation. In 2025-26, patients were legally represented in 2,520 (19%) hearings. The following table provides a more detailed breakdown of legal representation.

Table 33: Legal representation at hearings

	2025-26	2024-25	2023-24
Victoria Legal Aid	**9% (1,219)**	8% (1,030)	12% (1,281)
Mental Health Legal Centre	**9% (1,150)**	7% (967)	5% (518)
Victorian Aboriginal Legal Service	**1% (101)**	1% (110)	< 1% (54)
Private Lawyer	**< 1% (34)**	< 1% (37)	< 1% (35)
Other Legal Aid	**< 1% (16)**	< 1% (4)	< 1% (15)
Total legal representatives	**2,520**	2,148	1,903
Total hearings conducted	**13,274**	13,029	11, 29

2.15 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 34: Cases and hearings that did not meet statutory deadlines in 2025-26

	2025-26
Cases received out of time	4
Hearings adjourned by the Tribunal to be heard out of time	1
Hearings adjourned out of time due to health service not ready to proceed	1
Hearings adjourned out of time to enable patient time to access legal representation	1
Hearings listed out of time	6
Hearings listed out of time due to no capacity in the Tribunal hearing schedule	1
Hearings listed out of time due to Tribunal being unable to constitute a division	11
Hearings unable to proceed because the patient's treatment order had expired	3
Hearings unable to proceed because the Tribunal was unable to constitute a division	9
Total	37

2.16 Number of patients and hearings per patient

In early 2025, the Tribunal began to analyse 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.

*Table 35: Total number of patients and hearings**

	2025-26	2024-25	2023-24
Number of hearings	**12,975**	12,723	10,893
Number of patients	**6,468**	6,171	5,618
% change in hearings from previous year	**+2%**	+17%	+10%
% change in patients from previous year	**+5%**	+10%	+1%
Average number of hearings per patient	**2.0**	2.1	1.9

** This count of hearings excludes applications to deny access to documents and hearings adjourned on the papers.*

Table 36: Number of hearings conducted for each patient*

	2025-26			2024-25			2023-24		
	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	**2,559**	**39%**	**30%**	2,446	40%	19%	2,591	46%	24%
2 hearings	**2,318**	**36%**	**39%**	2,141	35%	34%	1,744	31%	32%
3 hearings	**988**	**15%**	**19%**	890	14%	21%	761	14%	21%
4 hearings	**369**	**6%**	**7%**	398	6%	12%	291	5%	11%
5+ hearings	**234**	**4%**	**5%**	296	5%	14%	231	4%	12%
Total	**6,468**	**100%**	**100%**	6,171	100%	100%	5,618	100%	100%

** This count of hearings excludes applications to deny access to documents and hearings adjourned on the papers.*

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 application to revoke) that necessitate a hearing.

Table 37: Number of hearings^ conducted by case combinations*

	2025-26	2024-25	2023-24
28-day hearing	**4,464**	4,330	3,768
28-day hearing and application for revocation	**407**	530	485
Application for a further treatment order	**5,504**	5,131	4,220
Application for a further treatment order and application for revocation	**220**	142	100
Application for a further treatment order and variation hearing	**271**	300	248
Application for a further treatment order, application for revocation and variation hearing	**14**	11	13
Application for revocation	**534**	759	718
Variation hearing	**549**	546	542
Application for revocation and variation hearing	**71**	79	59
28-day hearing (security patient)	**124**	82	97
28-day hearing and application for revocation (security patient)	**2**	3	1
Application for revocation (security patient)	**0**	0	4
6-month review (security patient)	**1**	0	0
Application for ECT (adult)	**716**	717	546
Application for ECT (young patient)	**12**	3	3
Application for ECT (adult not a patient)	**69**	74	72
Application for ECT (young person not a patient)	**0**	2	0
Neurosurgery for mental illness	**4**	5	4
Application to transfer patient to another service	**10**	6	12
Application to transfer a patient interstate	**2**	2	1
Application to transfer a patient's treatment interstate	**1**	1	0
Total	**12,975**	12,723	10,893

** This count of hearings excludes applications to deny access to documents and hearings adjourned on the papers.*

^ In order to align the count of hearings in tables 35 and 36 in Part 2.16, a hearing of an ECT application has been included as a stand-alone hearing and not combined with a concurrent treatment order matter.

2.17 Customer service

The Tribunal's service standards are published on its website and outline the service standards people can expect from Tribunal staff. 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 (see also complaints and feedback policy below).

In 2025-26, both service standards were met, with all email and website enquiries responded to in accordance with the service targets, and 90% of phone calls answered within 30 seconds.

2.17.1 Complaints & 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 2025-26 the Tribunal received 30 complaints and 15 pieces of feedback. These related to:

*Table 38: Number of complaints and feedback received in 2025-26 ^**

	Complaints	Feedback
Clarification of procedures	0	4
Conduct of hearings	21	6
Procedural fairness	2	6
Technical or administrative difficulty or error	6	0
Customer service	1	1
Total	30	15

^ *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 may not match the count of complaint or feedback types as each contact can raise multiple concerns.*

PART THREE
THE TRIBUNAL'S STRATEGIC INITIATIVES

3.1 Update of the Strategic Plan 2025–2028

In 2025–26, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA) and the *Mental Health and Wellbeing Act 2022* were amended to transfer forensic leave functions from the Forensic Leave Panel to the Tribunal from 1 September 2026. Following passage of the amendments, the Tribunal updated its Strategic Plan to include Strategic Priority 4 – Implement the reforms for approval of forensic leave under the CMIA.

Given the timeframe for commencement of these reforms, this new strategic priority needed to be the primary focus during 2025-26. Considerable work has been undertaken in close consultation with all stakeholders, however as it continues to be work in progress and not all critical matters have been settled, details of how the Tribunal will perform these functions will be contained in the 2026-27 Annual Report.

In addition to work on these reforms, the Tribunal progressed various other initiatives in its 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.

4 Implement the reforms for approval of forensic leave under the *Crimes (Mental) Impairment and Unfitness to be Tried) Act 1997*

From 1 September 2026, applications relating to forensic leave under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* will be heard and determined by the Tribunal.

Over the life of this plan the Tribunal will:

- Work with stakeholders to ensure that robust and efficient processes are in place for applications to be heard by the Tribunal upon commencement of the reforms.
- Following commencement, collaborate with stakeholders to refine and enhance procedures for forensic leave hearings.
- Undertake targeted work to ensure processes, including information products, meet the distinct needs of forensic residents.

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 in the Mental Health and Wellbeing Act

Section 21 of the *Mental Health and Wellbeing Act 2022* reflects the foundational theme of the Royal Commission's recommendations that lived experience should be at the centre of the mental health and wellbeing system. 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 commitment to embedding and elevating lived and living experience across its work. In 2025–26, this commitment was strengthened with the continued implementation of initiatives arising from the Valuing Lived Experience project and the ongoing partnership with the Tribunal Advisory Group (TAG).

The Tribunal acknowledges that its decisions affect people's liberty, autonomy, dignity and wellbeing, and that its processes can be stressful or distressing, particularly for people who have experienced coercion, as well as their families and carers. Embedding lived and living experience supports fair, transparent and trauma-informed practice, and strengthens decision making.

Last year we reported that in May 2025 the Tribunal's Governance Group had accepted all the recommendations of the final report of the Valuing Lived Experience project. This year we are pleased to confirm a range of initiatives were implemented:

- training for members and staff deepened understanding of lived and living experience, trauma informed practice, and the appropriate application of lived experience within the Tribunal context
- lived experience expectations were embedded within members professional competencies, appraisal processes and the Code of Conduct to promote meaningful reflection, accountability, and continuous improvement in practice
- supports for members and staff with lived experience were strengthened with a focus on psychological safety, inclusion and wellbeing
- access to resources and guidance to support capability development and reflective practice was enhanced.

A highlight of the year was a member forum that focused on lived and living experience which included a panel of lived experience leaders. The forum supported deeper engagement with lived experience perspectives and reinforced their relevance to Tribunal practice.

These initiatives occurred alongside long-standing strategies. The Tribunal continues to embed lived and living experience across its governance and leadership structures. The Senior Adviser Lived Experience contributes to policy development, quality improvement, governance, and organisational learning, and provides lived experience expertise to strategic and organisational initiatives. Lived experience membership of the Governance Group ensures that consumer and carer perspectives are reflected in governance discussions and organisational decision making.

Recruitment and appointment processes, induction and member support are also a focus. Lived experience representatives participate in member and senior staff selection and interview panels, and candidates are required to demonstrate their understanding of the importance of lived and living experience at the Tribunal. The Tribunal actively encourages applications from people with lived and living experience.

Lived and living experience is reflected in the Tribunal's core organisational frameworks. It is incorporated within induction processes for new members, reinforcing expectations about respect for and responsiveness to lived experience. Practice reflection groups for members with consumer and carer lived experience provide structured and confidential forums for members to reflect on how lived experience informs their practice and decision making. This broad program is designed to realise the public commitment in the Tribunal's Lived Experience Values Statement:

> ***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.***

We acknowledge that embedding lived and living experience requires ongoing attention and commitment. The Tribunal will continue strengthening its practice through learning, reflection and continuous improvement, so that lived and living experience remains central to its decision-making and organisational culture.

3.2.1 Tribunal Advisory Group

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

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

In 2025–26, the TAG farewelled Jeanette Murphy and Roger Moulton. The Tribunal thanks the outgoing TAG members for their significant contributions to the work of the Tribunal.

In 2025–26, the TAG welcomed three new members: Robert Dettmann as a Consumer TAG member; Franka Bywater as a Carer Workforce TAG member; and Marta King as a Carer Workforce TAG member. The Tribunal looks forward to continuing to learn from the expertise TAG members bring to the Tribunal's work.

This year TAG members contributed their experience and expertise to numerous strategic activities, including:

- the proposed Standards Project, including feedback on the standards of information that treating teams will provide the Tribunal for a hearing
- a review of the new statement of reasons template, with a focus on enhancing the clarity and consistency of written reasons that members prepare
- communications provided to consumers and carers when a hearing is delayed, missed or cancelled
- contributions to the Mental Health and Wellbeing Commission's Complaints Handling Project
- content presented to Tribunal members for the May 2026 Member Forum on Lived Experience
- a trial of sending Notice of Hearings via SMS.

3.3 Cultural safety initiatives for Aboriginal and Torres Strait Islander patients

In July 2025 the final report of the Yoorrook Justice Commission was tabled in Parliament. It included recommendations relating to legal representation and cultural safety in Tribunal hearings (Recommendation 78).

In October 2025 the Tribunal embarked on a three-year program to improve cultural safety for Aboriginal and Torres Strait Islander patients, with support from the Victorian Aboriginal Legal Service (VALS) and the Independent Mental Health Advocacy (IMHA) First Nations team.

The Tribunal's initial focus has been strengthening case management processes to support more culturally safe hearings. Two key initiatives began in May 2026: early identification of Aboriginal and Torres Strait Islander patients to facilitate enhanced case management processes; and proactive notification to treating health services including Aboriginal Liaison Officers to improve patient access to VALS and IMHA support.

The Tribunal's registry sent 91 case management emails to health services in May and June this year when hearings involving Aboriginal and Torres Strait Islander patients were scheduled. A further 60 proactive case management emails were sent to health services when an order for an Aboriginal or Torres Strait Islander patient was due to expire within six weeks. These initiatives were well received, supporting earlier engagement with culturally safe legal and advocacy services and enabling planning for a further hearing when it is anticipated a hearing will be needed.

The Tribunal will continue to work with VALS, IMHA, health services and other stakeholders in the second half of 2026 to design a pilot of a specialised hearing approach for Aboriginal and Torres Strait Islander patients. The pilot will explore all aspects of hearing operations, including case and list management, hearing processes, and incorporate evaluation processes. The pilot will launch in 2027 and the outcome will inform long-term improvements.

These initiatives reflect the Tribunal's commitment to delivering more culturally safe, accessible and responsive services for Aboriginal and Torres Strait Islander patients.

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.

	2025-26	2024-25	2023-24
APPROPRIATION			
Total	**$11,610,869**	$11,793,290	$13,041,551
EXPENDITURE			
Full and part-time member salaries	**$1,677,186**	$1,370,927	$1,615,577
Sessional member salaries	**$7,034,061**	$6,937,801	$5,849,324
Staff Salaries (includes contractors)	**$3,591,098**	$3,435,359	$3,036,272
Salary On costs	**$2,871,207**	$2,395,683	$2,060,593
Operating Expenses	**$840,610**	$696,710	$818,825
Total	**$16,014,162**	$14,836,480	$13,380,591
BALANCE			
Total*	**-$4,403,293**	-$3,043,190	-$339,040

** 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 DATA

Mental Health Tribunal workforce profile at 30 June 2026:

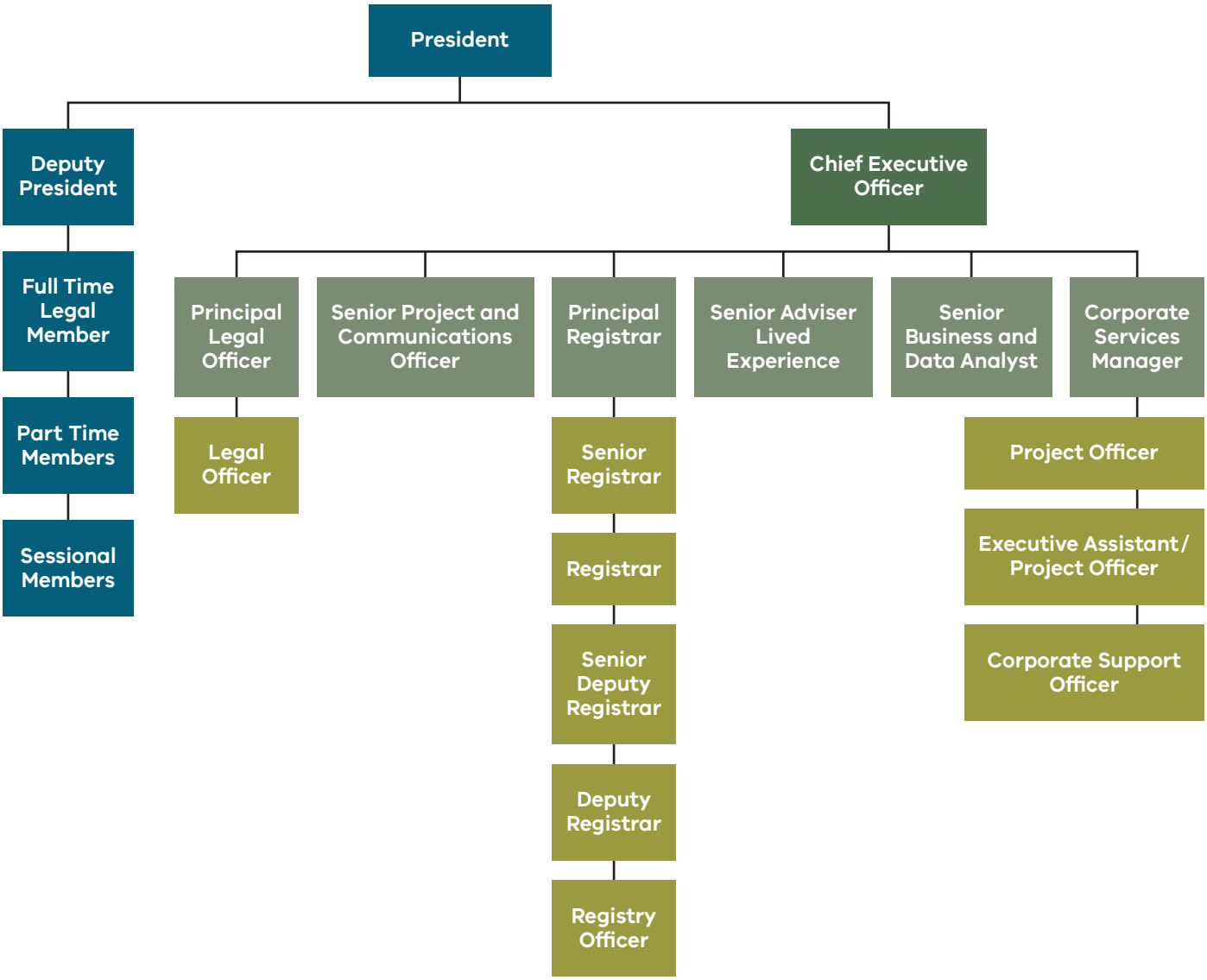
Tribunal staff

	All employees		Ongoing		Fixed term/seconded	
	Headcount	Filled FTE	Headcount	Filled FTE	Headcount	Filled FTE
Gender						
Female	31	27.2	23	20.4	8	6.8
Male	7	6.5	5	4.9	2	1.6
Non-binary and undisclosed	—	—	—	—	—	—
Classification						
VPS 2	6	5	3	3	3	2
VPS 3	11	9.8	8	7.2	3	2.6
VPS 4	8	7.4	6	5.4	2	2
VPS 5	8	7.3	7	6.5	1	0.8
VPS 6	4	3.2	4	3.2	-	-
Executive	1	1	-	-	1	1
Total	**38**	**33.7**	**28**	**25.3**	**10**	**8.4**

Tribunal members

	Full time and part time members		Sessional members	
	Headcount	Filled FTE	Headcount	Filled FTE
Gender				
Female	7	5.0	85	n/a
Male	5	3.0	52	n/a
Non-binary and undisclosed		—	1	—
Category				
Community	4	2.4	36	n/a
Legal	6	4.8	33	n/a
Psychiatrist	2	0.8	51	n/a
Registered Medical	—	—	18	n/a
Total	**12**	**8**	**138**	**—**

APPENDIX C
ORGANISATION CHART



APPENDIX D
MEMBERSHIP LIST AT 30 JUNE 2026

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 August 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	
Ms Melissa Bray	25 Feb 2021 – 1 Sept 2030 *Appointed to current position 2 Sept 2025*
Legal Member	
Mr Marcus Ibaceta	2 Sept 2025 – 1 Sept 2030 *Appointed to current position 2 Sept 2025*
Legal Member	
Ms Jo-Anne Mazzeo	10 June 2013 – 1 Sept 2030 *Appointed to current position 2 Sept 2025*
Psychiatrist Member	
Dr Michael McCausland	10 June 2018 – 9 June 2028 *Appointed to current position 15 Sept 2020*
Psychiatrist Member	
Dr Philip Price	10 June 2018 – 9 June 2028 *Appointed to current position 10 June 2023*
Community Member	
Mr Christian Cosma	10 June 2023 – 1 Sept 2030 *Appointed to current position 2 Sept 2025*
Community Member	
Dr Kylie McShane	29 June 1999 – 9 June 2028 *Appointed to current position 10 June 2023*
Community Member	
Ms Sarah Muling	25 Feb 2016 – 1 Sept 2030 *Appointed to current position 2 Sept 2025*
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 2030
Ms Troy Barty	1 June 2003 – 9 June 2028
Ms Wendy Boddison	7 Sept 2004 – 9 June 2028
Ms Jodie Burns	10 June 2023 – 9 June 2028
Mr Jeremy Cass	25 Feb 2021 – 1 Sept 2030
Mr Peter Cutting	10 June 2023 – 9 June 2028
Mr Robert Daly	10 June 2013 – 9 June 2028 *(Transitioned to sessional member 2 Sept 2025)*
Ms Arna Delle-Vergini	10 June 2018 – 9 June 2028
Ms Jennifer Ellis	25 Feb 2016 – 1 Sept 2030
Mr David Fanning	2 Sept 2025 – 1 Sept 2030
Ms Eleanore Fritze	2 Sept 2025 – 1 Sept 2030
Mr Philip Grano	2 Sept 2025 – 1 Sept 2030
Mr Brook Hely	25 Feb 2011 – 1 Sept 2030
Mr Gregory Levine	10 June 2023 – 9 June 2028
Ms Laura McDonough	2 Sept 2025 – 1 Sept 2030
Ms Robyn Mills	10 June 2023 – 9 June 2028
Mr Joel Orenstein	17 Dec 2024 – 1 Sept 2030
Ms Penelope Ralston	10 June 2023 – 9 June 2028
Ms Kristen Rose	17 Dec 2024 – 1 Sept 2030
Ms Natalie Sheridan-Smith	10 June 2023 – 9 June 2028
Ms Lisa Smith	2 Sept 2025 – 1 Sept 2030
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 2030
Dr Andrea Treble	23 July 1996 – 1 Sept 2030
Ms Katie Valentine	2 Sept 2025 – 1 Sept 2030
Ms Helen Versey	10 June 2013 – 9 June 2028
Ms Jade Werkmeister	2 Sept 2025 – 1 Sept 2030
Dr Bethia Wilson	10 June 2013 – 9 June 2028
Ms Renee Wilson	2 Sept 2025 – 1 Sept 2030
Ms Kate Windmill	2 Sept 2025 – 1 Sept 2030
Ms Tania Wolff	10 June 2018 – 9 June 2028
Ms Magdalena Wysocka	25 Feb 2021 – 1 Sept 2030

Sessional members	Period of appointment
Psychiatrist Members	
Dr Shruti Anand	25 Feb 2021 – 1 Sept 2030
Dr Mark Arber	25 Feb 2016 – 1 Sept 2030
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 2030
Prof Marie Bismark	24 March 2026 – 1 Sept 2030
Dr Ruth Borenstein	10 June 2018 – 9 June 2028
Dr Peter Braun	25 Feb 2021 – 1 Sept 2030
Dr Pia Brous	10 June 2008 – 9 June 2028
Dr Sue Carey	25 Feb 2011 – 1 Sept 2030
Dr Carrie Cheng	24 March 2026 – 1 Sept 2030
Dr Robert Chazan	25 Feb 2016 – 1 Sept 2030
Dr Peter Churven	10 June 2018 – 9 June 2028
Dr Eamonn Cooke	14 July 2009 – 9 June 2028
Dr Brett Coulson	24 March 2026 – 1 Sept 2030
Dr Rupak Dasgupta	24 March 2026 – 1 Sept 2030
Dr Beatrice Dowsett	24 March 2026 – 1 Sept 2030
Dr Melanie Jones	24 March 2026 – 1 Sept 2030
Dr Linda Kader	24 March 2026 – 1 Sept 2030
Dr Simone Keogh	24 March 2026 – 1 Sept 2030
Dr Fintan Harte	13 Feb 2007 – 1 Sept 2030
Dr Graham Hocking	10 June 2023 – 9 June 2028
Dr Jill Hosking	10 June 2023 – 9 June 2028
Dr Harsha Kadiveti	2 Sept 2025 – 1 Sept 2030
Dr Spiridoula Katsenos	9 Oct 2012 – 1 Sept 2030
Dr Melissa Lowe	10 June 2023 – 9 June 2028
Dr Barbara Matheson	9 Oct 2012 – 1 Sept 2030
Dr Kristine Mercuri	10 June 2023 – 9 June 2028
Dr Anthony Miach	2 Sept 2025 – 1 Sept 2030
Dr Peter Millington	30 Oct 2001 – 9 June 2028
Dr Emily Moriarty	2 Sept 2025 – 1 Sept 2030
Dr Ilana Nayman	9 Oct 2012 – 1 Sept 2030
Prof Daniel O'Connor	27 June 2010 – 1 Sept 2030
Assoc Prof Paul Robertson	24 March 2026 – 1 Sept 2030
Dr Amanda Rynie	25 Feb 2016 – 1 Sept 2030
Dr Bharathram Sathur Raghuraman	24 March 2026 – 1 Sept 2030
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 Rodney Smith	24 March 2026 – 1 Sept 2030
Dr Oladipo Sorungbe	10 June 2023 – 9 June 2028
Assoc Prof Dean Stevenson	25 Feb 2021 – 1 Sept 2030
Dr Katherine Tan	24 March 2026 – 1 Sept 2030
Dr Jennifer Torr	11 March 2014 – 9 June 2028
Dr Maria Triglia	25 Feb 2011 – 1 Sept 2030
Assoc Prof Roth Trisno	24 March 2026 – 1 Sept 2030
Dr Graham Vessey	24 March 2026 – 1 Sept 2030
Dr Ruth Vine	9 Oct 2012 – 1 Sept 2030
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 Member	
Dr Adeola Akadiri	25 Feb 2021 – 1 Sept 2030
Dr Hisham Almohandes	24 March 2026 – 1 Sept 2030
Dr Manu Bhatnagar	2 Sept 2025 – 1 Sept 2030
Assoc Prof Anthony Cross	10 June 2023 – 9 June 2028
Dr Kaye Ferguson	25 Feb 2016 – 1 Sept 2030
Dr James Fordyce	24 March 2026 – 1 Sept 2030
Dr Naomi Hayman	1 July 2014 – 9 June 2028
Dr Victoria Ho	2 Sept 2025 – 1 Sept 2030
Dr John Hodgson	1 July 2014 – 9 June 2028
Dr Claire Kembrey	24 March 2026 – 1 Sept 2030
Dr Marija Kirjanenko	10 June 2023 – 9 June 2028
Dr Kate Maxfield	24 March 2026 – 1 Sept 2030
Dr Helen McKenzie	1 July 2014 – 9 June 2028
Dr Stathis Papaioannou	1 July 2014 – 9 June 2028
Dr Shannon Price	24 March 2026 – 1 Sept 2030
Dr Nicole van der Nagel	24 March 2026 – 1 Sept 2030
Dr Maxine Waycott	10 June 2023 – 9 June 2028
Dr Jo-Anne Zappia	24 March 2026 – 1 Sept 2030

Sessional members	Period of appointment
Community Members	
Dr Nadja Berberovic	25 Feb 2021 – 1 Sept 2030
Ms Daisy Beyer	2 Sept 2025 – 1 Sept 2030
Dr Lisa Brophy	10 June 2008 – 9 June 2028
Dr Leslie Cannold	10 June 2013 – 9 June 2028
Dr Brianna Chesser	2 Sept 2025 – 1 Sept 2030
Ms Katrina Clarke	10 June 2018 – 9 June 2028
Ms Paula Davey	29 Oct 2014 – 9 June 2028
Mr Ashley Dickinson	25 Feb 2011 – 1 Sept 2030 *(Transitioned to sessional member 2 Sept 2025)*
Ms Angela Eeles	10 June 2018 – 9 June 2028
Dr Josh Fergeus	25 Feb 2021 – 1 Sept 2030
Ms Katherine George	10 June 2023 – 9 June 2028
Mr John Griffin	25 Feb 2011 – 1 Sept 2030
Ms Renee Harrison	10 June 2023 – 9 June 2028
Ms Philippa Hemus	25 Feb 2021 – 1 Sept 2030
Mr Ben Ilsley	10 June 2013 – 9 June 2028
Ms Erandathie Jayakody	10 June 2018 – 9 June 2028
Mr John King	1 June 2003 – 1 Sept 2030
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 2030
Ms Tamara Lobato	2 Sept 2025 – 1 Sept 2030
Ms Anne Mahon	10 June 2013 – 9 June 2028
Mr Aroon Naidoo	25 Feb 2016 – 1 Sept 2030
Mr Jack Nalpantidis	23 July 1996 – 1 Sept 2030
Ms Marie Piu	2 Sept 2025 – 1 Sept 2030
Ms Alexa Powell	2 Sept 2025 – 1 Sept 2030
Ms Linda Rainsford	10 June 2013 – 9 June 2028
Dr Cheryl Reed	2 Sept 2025 – 1 Sept 2030
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 2030
Ms Charlotte Stockwell	10 June 2013 – 9 June 2028
Ms Tracey Taylor	10 June 2023 – 9 June 2028
Ms Helen Turley	2 Sept 2025 – 1 Sept 2030
Prof Penelope Weller	10 June 2013 – 9 June 2028
Mr Kenton Winsley	10 June 2023 – 9 June 2028

APPENDIX E
COMPLIANCE REPORTS

In 2025-26, 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 documents normally requested under the FOI Act is hearing-related documents 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 outside of the FOI Act.

This financial year, the Tribunal received 50 requests for access to documents. In 22 of the requests, the information that was the subject of the request was information that related to the applicant's hearings with either the Tribunal or the former Mental Health Review Board; accordingly, the Tribunal released the documents administratively. Three of the requests required a formal response. Sixteen of the requests were not proceeded with or were withdrawn, no documents were found in relation to four requests and two requests were transferred to the treating mental health service. The FOI Act did not apply to two requests, and one request was the subject of a VCAT appeal which was yet to be finalised.

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 2025-26 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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