annual report

2019/20

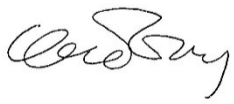
27 August 2020

The Honourable Roger Cook MLA
Deputy Premier; Minister for Health; Mental Health
13th Floor
Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Deputy Premier

I am pleased to present the Mental Health Tribunal's Annual Report in accordance with section 488 of the *Mental Health Act 2014* for the period 1 July 2019 to 30 June 2020.

Yours faithfully



Karen Whitney
President
Mental Health Tribunal

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Overview of the Mental Health Tribunal

The *Mental Health Act 2014* (WA) (the Act) permits psychiatrists in Western Australia to treat certain patients without their consent. The Act refers to these patients as 'involuntary patients'. A psychiatrist makes a patient 'involuntary' by making an 'involuntary treatment order'.

Without adequate safeguards, the power to make involuntary treatment orders could be abused. Parliament created the Mental Health Tribunal (the Tribunal) to protect patients from potential abuse of the powers under the Act. The Tribunal is an independent decision-making body established by the Act to safeguard the rights of involuntary patients in Western Australia.

What we do

The Tribunal's main role is to review every involuntary treatment order made by a psychiatrist in Western Australia within 35 days (10 days for children) from the day the order is made. The Tribunal reviews each order again every three months (every 28 days for children) whilst the order remains in place. The purpose of the Tribunal's review is to determine whether the patient still needs the involuntary treatment order. The Tribunal can also decide other questions under the Act. Patients or treating teams can ask the Tribunal to decide these questions by filling out a form (an application).

The Tribunal makes decisions based on medical reports prepared by the patient's psychiatrist and treating team and other information provided at a hearing. A hearing is a meeting where the Tribunal listens to participants' views on a question and then decides. The Tribunal usually holds its hearings at the hospital or health service treating the patient. This is for the convenience of participants only. The Tribunal is independent and is not part of the treating team or the health service.

The Tribunal expects the patient's psychiatrist and treating team to attend the hearing. The Tribunal also strongly encourages patients and their families to attend hearings. Patients may bring an advocate or a lawyer to speak for them if they choose.

At the end of a hearing, the Tribunal decides the question in issue. The Tribunal tells the participants its decision, and the reasons for its decision.

Who we are

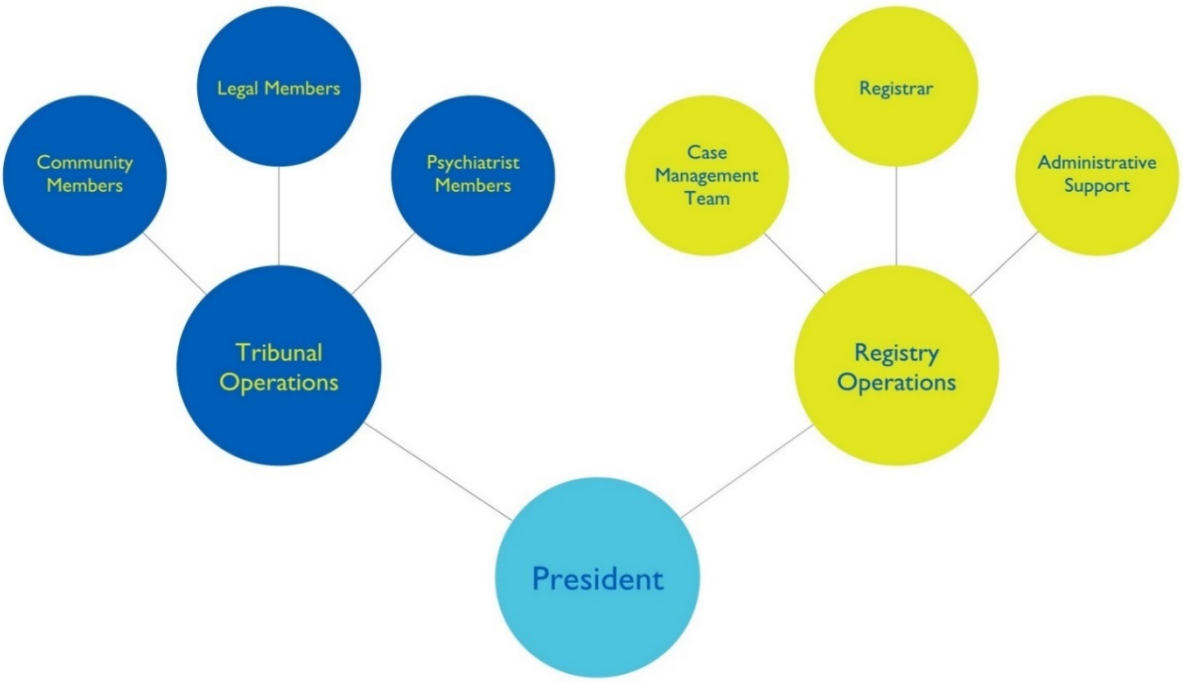
The Tribunal has a President and Tribunal members who make decisions under the Act. When the Tribunal holds hearings, it usually sits in panels of three. One member is a lawyer, the second member is a psychiatrist, and the third member is a community member. Tribunal members are independent statutory officers appointed by the Governor on the recommendation of the Minister. They do not work for the hospital or health service treating the patient.

The current President of the Tribunal is Karen Whitney. She is a legal member, appointed as President on 30 December 2017 for five years. On 30 June 2020, the Tribunal also had:

- 13 active legal members (two full-time, four part-time and seven sessional members);
- 13 active sessional psychiatrist members; and
- 18 community members (two full-time, two part-time and 14 sessional members).

A further 16 sessional members (two legal and 14 psychiatrist) are currently inactive. Members become inactive if they are not available for hearings because of extended leave, ongoing potential conflicts of interest, or other extended unavailability. A full list of Tribunal members is at Appendix One.

The Tribunal also has a Registry. The Registry is the office that supports the Tribunal members by scheduling hearings and processing hearing materials. It has a Registrar and six staff: a Senior Case Management Officer, three Case Management Officers, a Records Officer and an Executive Assistant. The Registrar is responsible under the Act for scheduling hearings on a timely basis. The Registrar is also responsible for notifying parties when and where hearings will take place.



Our strategic objectives

The Tribunal has four primary strategic objectives:

- to achieve high quality patient-centred outcomes in every matter;
- to support stakeholder participation in the hearing process;
- to improve how we work and maximise our use of technology; and
- to build our capacity and make best use of our resources.

The Tribunal's Strategic Plan (including its vision, mission and values) is at Appendix Two.

President's Report

The 2019/20 financial year was a period of unprecedented challenge and adaptation for the Tribunal. Many of the challenges arose directly from the COVID-19 public health emergency. The Tribunal rose to these challenges, using them as opportunities to accelerate progress towards achieving its strategic objectives. I highlight in this report the Tribunal's key achievements, its most significant issues and noteworthy events during the past financial year.

Key achievements

Appointment of the Tribunal's first full-time and part-time Tribunal members

Since its commencement as the Mental Health Review Board in 1997, the Tribunal has been comprised of a President and sessional members. As the workload grew, this model of operation became more expensive, as the Tribunal paid sessional surcharges for work which could be performed more efficiently by full-time members. The commencement of the new Act in November 2015 saw the number of hearings listed annually by the Tribunal increase by 84% between 2013/14 (the last full financial year before the commencement of the Act) and 2018/19. During the same period recurrent funding allocated to the Tribunal increased only 39%.

To address the increasing costs of operating the Tribunal, without compromising patient experience, in 2019 the Minister authorised recruitment of members on a full and part-time basis. Positions were advertised in June 2019, and more than 160 applications were received. The calibre of the candidates was impressive, including a retired District Court Judge, existing members of the Administrative Appeals Tribunal and existing sessional members of the Tribunal.

On 29 October 2019, the Governor in Executive Council, on the recommendation of the Minister, made the following appointments under section 476 of the Act for a period of five years (* denotes sessional member of the Tribunal prior to this appointment):

Legal Members

- Ms Jeanette de Klerk (full-time)*
- Ms Camille Woodward (full-time)
- Mr Peter Curry (part-time)*
- Ms Christine Kannis (part-time)
- Dr Hannah McGlade (part-time)*
- Her Honour Catherine (Kate) O'Brien (part-time)
- Ms Nicola Findson (sessional)
- Ms Jennifer Wall (sessional)*

Community Members

- Ms Teresa (Ted) Ellis (full-time)
- Dr Michael Lenney (full-time)
- Ms Manjit Kaur (part-time)*
- The Hon Keith Wilson AM (part-time)*

Psychiatrist Members

- Dr Julie Nadine Caunt (sessional specialist Child and Adolescent Psychiatrist)
- Dr Lynne Cunningham (sessional general psychiatrist)
- Dr Sally Kelderman (sessional specialist Child and Adolescent Psychiatrist)
- Dr Helen Milroy (sessional specialist Child and Adolescent Psychiatrist)
- Dr Paul O'Hara (sessional general psychiatrist)
- Dr Kavitha Vijayalakshmi Lakshminarayanan (sessional specialist Child and Adolescent Psychiatrist)

Members commenced their new appointments between 30 October 2019 and 2 February 2020. The new members have now settled into the Tribunal well and are valued contributors to the Tribunal's operations. They have coped admirably with the challenges brought by COVID-19. I congratulate them on their appointments and welcome them to the Tribunal.

IT system analysis and case management system option review

As reported in earlier Annual Reports, the Tribunal's existing case management system (Microsoft Dynamics CRM 2013, known as 'ICMS') was inherited from the Tribunal's predecessor body, the Mental Health Review Board. It was developed in 2013 and configured for the *Mental Health Act 1996* (WA) (the 1996 Act). ICMS functions primarily as a patient database and basic scheduling tool. It lacks configuration for member rostering, electronic order production and distribution, document generation, and other key functions of contemporary 'end-to-end' case management systems.

After the Act commenced in late 2015, ICMS no longer reflected current legislation. This reduced its functionality even further. Although it was originally intended to be reconfigured in 2016, this did not occur. Because of its limitations, the Tribunal ceased using ICMS during 2019 for most functions, reverting to manual systems for member rostering, order production and distribution, document generation, and other functions.

The Tribunal purchases IT support from the Mental Health Commission (the Commission) and during 2019/20 the Tribunal worked with the Commission to decide whether to invest in further works to ICMS or a new contemporary 'end-to-end' case management system. The Tribunal retained PriceWaterhouseCoopers (PWC) to gather and analyse the relevant information.

PWC reported that from a technological perspective, ICMS is no longer suitable for further configuration or upgrade. The technology for the Tribunal's version of the product was rendered obsolete in late 2016. The only viable option is to replace the product with a contemporary 'end-to-end' cloud-based case management system. This is the current 'industry standard' in court and tribunal case management. It functions as much more than a patient 'database'. In the Tribunal's context, it would also manage the

progress of every involuntary treatment order made in Western Australia through the Tribunal's processes. Doing so would permit the Tribunal to streamline its processes and increase efficiencies.

PWC conducted an initial market scan of options available to the Tribunal, identifying several potentially suitable products, with prices ranging from $700,000 - $2M. The Tribunal submitted a business case for funding to Treasury in January 2020 for review by the Expenditure Review Committee. Unfortunately, however, because of the impact of COVID-19, delivery of the 2020/21 State Budget has been delayed until 8 October 2020. The significant impact of COVID-19 on the State's economic position will likely alter the chances of this essential proposal being funded.

Nevertheless, the Tribunal continues to work with PWC to finalise a list of technical requirements for the case management system in preparation for tender (when funding becomes available). Meanwhile, the Tribunal continues to innovate, to achieve low-cost temporary solutions in support of its strategic objectives.

Major improvements in Tribunal statistical reporting

The inability of ICMS to collect quantitative data to determine compliance with the Act has been an ongoing concern for me since my appointment. This issue was first raised in recommendations made by the Commission in its *Post-Implementation Review of the Mental Health Act 2014* in 2018 (the Post-Implementation Review):

- Recommendation 22: 'In order to determine compliance with the Act, the [Tribunal] to facilitate the ongoing collection of all relevant quantitative data regarding [the Tribunal's hearings] for further data analysis and to contribute to the statutory review of the Act.'
- Recommendation 30: 'The [Tribunal] to improve systems and processes to improve data collection to determine compliance with the requirements of the Act, which will assist with obtaining evidence of the [Tribunal's] functions, to better identify and ensure compliance with the Act in this regard and inform the statutory review of the Act.'

Although PWC has recommended replacing ICMS with a contemporary 'end-to-end' cloud-based case management system, the process of securing funding is long and difficult. During 2018/19, as an interim solution, the Tribunal explored low-cost alternative solutions, including the possibility of gathering and recording statistics manually. During 2019, the Registry team created a sophisticated Excel template for recording details of every hearing conducted by the Tribunal with a view to creating a data source from which to report:

- the Tribunal's compliance with its statutory timeframes;
- the number of matters involving children;
- the outcomes of matters considered by the Tribunal;
- its rates of, and reasons for, adjournments; and
- the extent to which patients, doctors and other stakeholders utilise the dispute resolution powers vested in the Tribunal under the Act.

The Tribunal commenced recording statistics using its new template in July 2019. This Annual Report records our first year of data in Performance and Statistics. We are delighted to be able to report statistics in the following areas for the first time:

- the number of applications made to the Tribunal under sections 390(1)(a)-(c), 390(1)(d)-(g), 391(a), 392, 396, 398(1), 410, 417, 423, 430, and 434 and the percentage of such applications decided in favour of the applicant;
- the number of times the Tribunal was required to adjourn a convened hearing, and the reasons why the adjournments were required;
- the rates of compliance with the Tribunal's statutory timeframes for conducting initial and periodic review hearings; and
- the breakdown between adult and children's proceedings, and differences in compliance with statutory timeframes for each.

This data is essential to understanding and managing the Tribunal's operations. For example, based on this data we are now aware that 55% of adjournments are primarily to address the adequacy of medical evidence or the attendance of members of the treating team. To address this I have commenced liaison with the executives and clinical leads of each statutory health service provider to explore solutions. Likewise, now that we are aware that 27% of adjournments are to address patient or supporter attendance, the Registrar can explore supplemental options for hearing notification (such as email and sms reminders) and alternative means of attendance (such as secure online meeting rooms) to improve attendance rates.

This data will be invaluable for the Minister's upcoming review of the Act pursuant to section 587. It will also assist in understanding any non-compliance with the Act.

There are numerous risks in relying on manually-compiled statistics (discussed later). Furthermore, manually-compiled statistics are highly labour-intensive and time-consuming to gather, record, audit and report. Nevertheless, I am proud of the Tribunal's proactive approach to finding innovative and low-cost temporary solutions to the matters raised in the Post-Implementation Review. This is a major achievement and I congratulate the entire Registry team for its innovation and hard work in this painstaking task.

In the interest of transparency and accountability, during the third quarter of 2019/20 the Tribunal also commenced reporting of its quarterly statistics on the Tribunal's website.

Roll out of electronic hearing files

On 12 December 2019, the State Records Commission approved the Tribunal's draft Record Keeping Plan under section 23 of the *State Records Act 2000* (WA). The Tribunal was organising the next stage of operationalising its approved electronic document and records management system (EDRMS) when COVID-19 intervened.

The Tribunal's hearing files have always been entirely paper-based. Hearing files include highly sensitive documents such as copies of involuntary treatment orders, medical reports, and original Tribunal orders. Currently the Tribunal holds more than 11,000 paper hearing files.

The Tribunal's reliance on paper hearing files has been an ongoing issue for several reasons. It results in expensive requirements for offsite storage and requires a complex manual system of locating and recalling Tribunal hearing files. It also means that Tribunal members must collect paper hearing files, transport them to various hearing venues to conduct hearings, and return them to the Tribunal at the end of a long hearing day. The need to factor this into a member's day means that fewer hearings can be listed each day. It also raises significant risks of a catastrophic loss of original records and breach of privacy.

In March 2020, it became apparent that Registry staff and Tribunal members would need to work from home to guarantee continuity of hearings during the COVID-19 pandemic. The Commission made secure laptops available to Registry staff and key Tribunal members and accelerated the roll out of Office 365 to enable hearings to continue electronically. At home, however, members and staff could not access paper hearing files or keep them up to date. Given the predicted length of the lock-down and the Tribunal's limited resources it was evident that it would be impracticable and inefficient to reconstruct and update thousands of paper hearing files upon returning to the office.

Considering the significant issues and risks arising from the Tribunal's practice of keeping paper hearing files, the Tribunal accelerated its transition to electronic hearing files. The Registrar devised and implemented a simple electronic filing system suitable for hearing files for ongoing use. The Tribunal accordingly rolled out fully electronic hearing files on 1 April 2020. Tribunal members now prepare electronic orders contemporaneously at the end of each hearing. In June 2020, full-time and part-time members were allocated portable electronic devices (Microsoft Surface Go with mobile sim, pen, keyboard, and mouse) to permit ongoing secure access to electronic hearing files during hearings.

Once again, I am proud of the Tribunal's flexibility and proactivity in finding solutions to the challenges raised by COVID-19 generally, and in accepting the roll out of electronic hearing materials without the opportunity for consultation or training. This was integral to the Tribunal's continuation of full operations during the pandemic. This is a major achievement and I congratulate the entire Tribunal team for making this happen.

Increasing public confidence in the Tribunal's role

In earlier Annual Reports, I noted the need to increase public confidence in the Tribunal's role as an independent decision-maker, in response to comments from an online survey conducted as part of the Post-Implementation Review process. These comments suggested that the Tribunal too frequently 'deferred' to the views of the treating psychiatrist in its decision-making.

Public confidence in the Tribunal's independence requires that every hearing be procedurally fair. Procedural fairness requires that:

- patients be notified of the date, time, and place of the hearing and be provided with copies of all relevant documents (especially the psychiatric report prepared by the treating psychiatrist as evidence) with reasonable time to prepare;
- patients be given an adequate opportunity to put their position to the Tribunal and respond to the psychiatric evidence during the hearing; and

- the Tribunal be free from bias, including actual bias or apprehended bias (apprehended bias is where a fair-minded lay observer might reasonably apprehend that a decision-maker might not bring an impartial or unprejudiced mind to the resolution of the decision).

Bias can be inferred from a range of behaviours as well as a member's past or present activities and associations. Some activities and associations will likely give rise to a reasonable apprehension of bias. For example:

- a member's personal friendship (but not a mere acquaintance) or a family relationship with a participant in the hearing (including the patient, the treating psychiatrist, or a legal representative);
- a member's professional association with a participant in the hearing relating to the subject matter of the proceedings (for example, where a psychiatrist member previously treated the patient, or where the psychiatrist member worked closely with the treating psychiatrist and has pre-existing views about the psychiatrist's credibility or skill); or
- a member's involvement in professional activities which may require appearance before the Tribunal (such as a member's involvement in treating involuntary patients).

During the past year, the Tribunal has taken the following steps towards providing the highest levels of procedural fairness in hearings, with the aim of increasing public confidence in the Tribunal's independence.

Increasing the notice period for hearings and listing them earlier

During the past year, the Tribunal has been moving towards listing matters 21 days (rather than 14 days) prior to hearing. This provides patients, families and supporters, treating teams, and advocates/lawyers with more time to prepare for the hearing.

Unfortunately, this does have the effect of increasing the number of matters which are vacated when patients are discharged prior to hearing. Nevertheless, the earlier the patient is discharged the more likely that the Tribunal will be able to fill the spot with another hearing (such as a child hearing or other matter with a shorter timeframe for listing).

The Tribunal also commenced listing periodic review hearings earlier within the timeframe for review, rather than later. Each periodic review has a narrow 'window' when it can be listed: no earlier than 21 days before the day the review period expires for adults and no earlier than 7 days before the day the review period expires for children. The Tribunal now lists periodic review hearings as early within the review window as permissible. This helps ensure that patient hearings are regularly conducted on a timely basis.

Increasing awareness of the need for early patient access to psychiatric reports

The treating psychiatrist's report is the cornerstone of the hearing evidence. Other than in exceptional circumstances (such as when access has been restricted by the psychiatrist under section 249 of the Act), procedural fairness requires that the patient receive a copy of the report in advance of the hearing. The Tribunal requests that reports be provided to patients and to the Tribunal three days prior to the hearing.

Because of competing demands, frequently psychiatrists are unable to achieve the three-day deadline. The Tribunal must then assess, in the circumstances of each case, whether the patient has received the report with 'reasonable' time to prepare. If not, the matter must be adjourned.

During 2019/20, the Tribunal began tracking the number of and reasons for adjournments. This data has provided the basis for discussions with health service providers reinforcing the importance of the psychiatric report and the need for the patient to have early access to it. We will continue to work on this in the future.

Increasing hearing time

During the current financial year, the Tribunal responded to feedback from stakeholders that hearing time should be increased to provide patients with more time to put their position to the Tribunal and respond to the psychiatric evidence during the hearing. Accordingly, in most matters, the Tribunal has increased the time to one hour per hearing.

Nevertheless, there are some hospitals where this is not possible because of exceptionally high rates of patient discharge in the 48 hours before the hearing. In these hospitals, the high rate of late discharge means that several hearings may fall away on the day before the hearing, leaving more time for those that proceed. In most cases, this serves to increase the available hearing time to one hour.

Increasing scrutiny of potential concerns about apprehended bias

All the Tribunal's psychiatrist members are sessional, which means that they work on an *ad hoc* basis as needed. Some are retired from practice, but about half are currently employed as consultant psychiatrists for WA health service providers in a part-time or locum capacity. A concern frequently raised by patients and advocates is whether, in the circumstances, the Tribunal's psychiatrist members are 'sufficiently independent'. This concern is an example of potential 'apprehended bias'.

To ensure that there is no actual or apprehended bias, the Tribunal sends out a conflict check to Tribunal members one week before the hearing with the names of known participants. All Tribunal members then consider whether any of the participants or venues raise issues about actual or apprehended bias. If a conflict arises, the member is replaced prior to the hearing.

During the past year, the Tribunal has commenced additional steps to further reduce the likelihood of potential 'apprehended bias'. One important step is to ensure that psychiatrist members who are listed for hearings are not actively treating involuntary patients. Neither Tribunal members nor patients ought to be in a situation where the Tribunal evaluates the evidence of a Tribunal colleague. All psychiatrist members are required to inform the President when they are actively treating involuntary patients and may be moved to the inactive list until their employment circumstances change. Inactive members do not conduct hearings or receive confidential Tribunal communications. They are not eligible to participate in any professional development activities involving discussions about Tribunal matters or activities.

Another important step is continuing to educate members about ways to reduce the potential for apprehended bias. The Tribunal continues to reinforce the message that members must avoid all contact with hearing participants (including the treating psychiatrist or treating team) except during the hearing. All

pre-hearing and post-hearing contact with hearing participants must be performed by Registry staff, and members are frequently reminded that it is inappropriate to have contact outside a hearing with participants about the hearing, the hearing process, the patient, any other patient, or any matter.

Professional development

Finally, the Tribunal continues to focus on professional development generally to ensure the highest calibre, procedurally-fair and consistent decision-making in a therapeutic setting.

The Tribunal's April 2020 whole-of-Tribunal training involved Tribunal members participating in an Aboriginal Cultural Awareness and Understanding Workshop delivered by Mr Danny Ford on behalf of Auspire – The Australia Day Council WA. Thirty-two Tribunal members attended the half-day seminar. The unanimous view was that the program was the best members had ever participated in, and we thank Mr Ford for his excellent presentation.

In addition to formal whole-of-Tribunal training, members continue to meet periodically within their specialist areas to discuss issues. Legal members participate in a formal continuing professional development program monthly, during which they discuss legal issues arising under the Act. This is to ensure consistent application of the legislation by Tribunal legal members. Psychiatrist members also participate in monthly peer review meetings.

Additionally, this year four Tribunal members (one legal member, two community members and a psychiatrist member) completed the Council of Australasian Tribunals' (COAT) eight-week online member induction program. COAT's online interactive training program is designed for recently appointed Tribunal members. It offers practical guidance on carrying out the challenging role of a Tribunal member in a collegial and supportive environment. Congratulations to all members completing the program. Three more members are enrolled in the program in 2020/21.

Development of a standard medical report template

As noted in last year's report, during 2018/19 the Tribunal's psychiatrist members engaged in a project to create a standard medical report template for treating psychiatrists to use in reporting to the Tribunal on the current status of patients at hearings. After significant refining and consultation with external treating psychiatrists, the Tribunal conducted a trial of the medical report template during the month of May 2019. The Tribunal then assessed the feedback arising from the trial and undertook further refinements to the template during 2019/20. The final version will be rolled out in 2020/21.

Significant issues

The most immediate issue for the Tribunal's operations remains the case management system. The Tribunal requires a funding commitment of at least $700K for investment in a contemporary end-to-end case management system. As noted earlier, the Tribunal submitted a business case for funding to Treasury in January 2020 for review by the Expenditure Review Committee. Unfortunately, however, because of the impact of COVID-19, delivery of the 2020/21 State Budget has been delayed until 8 October 2020.

In the meanwhile, the Tribunal continues to innovate low-cost temporary solutions to advance its strategic objectives. We have achieved significant gains by reverting to manual systems (such as increased access to statistical data and production of more professional orders and notices). Nevertheless, manual activities increase the risk of error, compromising the integrity of the Tribunal's records and data. Manual data collection and reporting are labour-intensive, less efficient and increase operating costs. Increased time spent on manual activities interferes with performance of core functions.

Investment in a contemporary end-to-end case management system is essential for the Tribunal to efficiently and effectively ensure compliance with its statutory functions. The Tribunal will continue to pursue a funding commitment of at least $700K for investment in a case management system.

Notable events and thanks

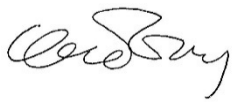
During the 2019/20 financial year, the following Tribunal members resigned, retired, or did not seek reappointment when their terms expired:

- Dr Nada Raich (psychiatrist member on 1 July 2019)
- Maxinne Sclanders (community member on 1 May 2020)

On behalf of the Tribunal I thank them for their involvement and wish them well for the future.

Also, during 2019/20, Jeanene Rodrigues-Smith joined the Tribunal as its Registrar. Ms Rodrigues-Smith was previously the Registry Services Manager of the Western Australian Industrial Relations Commission and Western Australian Industrial Magistrates Court. She was appointed Registrar on 13 January 2020 and we welcome her to the Tribunal team.

Finally, I thank all Tribunal members and Registry staff for their continuing support during the 2019/20 financial year. I remain grateful to the Deputy Premier The Honourable Roger Cook MLA and his staff, the Acting Mental Health Commissioner Jennifer McGrath, and the staff of the Commission (particularly the Corporate Services team) for their ongoing support.



Karen Whitney
President

The Tribunal's Functions

The Tribunal is an independent decision-making body established by the Act to safeguard the rights of involuntary patients in Western Australia.

The Act permits psychiatrists in Western Australia to treat certain patients without their consent. The Act refers to these patients as 'involuntary patients'. A psychiatrist makes a patient 'involuntary' by making an 'involuntary treatment order'. There are two types of involuntary treatment orders. An inpatient treatment order requires the patient to stay in hospital for treatment without consent. A community treatment order requires treatment without consent, but in the community rather than in hospital.

The Tribunal's main role is to review every involuntary treatment order made by a psychiatrist in Western Australia. However, the Tribunal can also decide many other questions under the Act. This section outlines the Tribunal's hearing process and the different types of decisions the Tribunal makes.

Conducting hearings

The Tribunal makes decisions based on medical reports prepared by the patient's psychiatrist and treating team and other information provided at a hearing. A hearing is a meeting where the Tribunal listens to participants' views on a question and then decides.

The Act provides many rules for the hearing process. The hearing must be as informal as possible. It must not be overly technical. It must only be as long as it needs to be. The hearing must be procedurally fair. It must also be private. The Act limits publication of private patient information and provides criminal penalties for unauthorised disclosure of such information.

When the Tribunal holds hearings, it usually sits in a panel of three. One member is a lawyer, one is a psychiatrist, and the third is a community member. The legal member is always the 'presiding member'. This means that the legal member manages the hearing and delivers the decision on behalf of the three Tribunal members. Legal members also decide all questions of law (including questions about how the law applies to the facts). A majority of the three members decides other questions.

Tribunal proceedings are free. The Tribunal does not charge application or hearing fees.

The Tribunal usually holds its hearings at the hospital or health service treating the patient. This is for the convenience of participants only. The Tribunal is independent and is not part of the treating team or the health service. Sometimes, hearings will be by videoconference.

The Tribunal expects the patient's psychiatrist and treating team to attend the hearing. The Tribunal also strongly encourages patients and their families to attend the hearings. Patients may bring an advocate or a lawyer to speak for them if they choose. Where required, the Tribunal provides interpreters.

At the hearing, the Tribunal allows each party to call evidence, examine or cross-examine witnesses, and make submissions. The formal rules of evidence do not apply.

In conducting hearings and making decisions, the Tribunal must have regard to the objects of the Act (s 10) and the Charter of Mental Health Care Principles. The objects of the Act and the Charter are reproduced at Appendix Three.

At the end of each hearing, the Tribunal tells the participants its decision and the reasons for its decision. Parties who request reasons are given a transcript of the oral reasons provided at the hearing.

Types of hearings

Initial and periodic reviews

The Tribunal's main role is to review every involuntary treatment order made by a psychiatrist in Western Australia within 35 days (10 days for children) from the day the order is made. This is an 'initial review' (s 386). The Tribunal reviews each order again every three months (every 28 days for children) whilst the order remains in place. This is a 'periodic review' (s 387). For patients who have been on a community treatment order for more than a year, the Tribunal reviews the order every six months.

The purpose of the Tribunal's initial and periodic reviews is to determine whether the patient still needs the involuntary treatment order.

Requested reviews

Patients and other interested persons can also complete an application form to ask the Tribunal to review certain types of orders. The Tribunal will then list a hearing to review the order. These are 'requested reviews' (s 390). The Tribunal can review:

- involuntary treatment orders, to decide whether the patient still needs the order (s 390(1)(a));
- inpatient treatment orders, to decide whether the patient still needs the order (s 390(1)(b));
- community treatment orders, to decide whether the terms of the order are appropriate (s 390(1)(c));
- orders authorising transfer of involuntary patients to or between authorised hospitals (s 390(1)(d));
- orders transferring patient responsibility between supervising psychiatrists (s 390(1)(e));
- orders transferring patient responsibility between treating practitioners (s 390(1)(f)); and
- orders transferring certain inpatients interstate (s 390(1)(g)).

The Tribunal can also review these orders on its own initiative (s 391).

Applications for declaration about the validity of treatment orders

Patients and other interested persons can complete an application form to ask the Tribunal to declare that certain orders are (or were) valid or invalid (ss 398 and 400). These include:

- involuntary treatment orders;
- continuation orders; or
- variation orders.

If the order is no longer in force at the hearing date, the Tribunal may decide to hear the application anyway if it is satisfied the application raises a question of law or a matter of public interest (s 403).

Applications to review admission of long-term voluntary inpatients

Patients and other interested persons can also complete an application form to ask the Tribunal to review the admission of long-term voluntary inpatients (s 405(1)). A long-term voluntary inpatient is:

- an adult who has been a voluntary inpatient for more than six months; or
- a child who has been a voluntary inpatient for more than three months (s 404).

After completing such a review, the Tribunal may recommend the treating psychiatrist:

- reconsider the need for the admission;
- prepare and regularly review a treatment, support and discharge plan for the patient; or
- discharge the patient (s 408).

The Tribunal has the power to make recommendations only.

Applications to approve electroconvulsive therapy

Psychiatrists cannot use electroconvulsive therapy (ECT) on certain patients without the Tribunal's approval. These patients include:

- children aged between 14 and 17; and
- adult involuntary patients or mentally impaired accused (s 409).

If a psychiatrist recommends ECT for one of these patients, the psychiatrist must complete an application form to ask the Tribunal for permission to perform ECT (s 410). The application must identify why the patient's psychiatrist recommends ECT and provide a treatment plan.

In deciding whether to approve ECT, the Tribunal must have regard to the *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia* (s 413). The Tribunal must also have regard to all the factors in section 414 of the Act, including:

- the patient's wishes;
- the views of the patient's parent or guardian (for children);
- the views of the patient's close family member, carer, and nominated person;
- why ECT should be performed;
- the consequences of not performing ECT;
- any significant risk of performing ECT;
- whether ECT will promote and maintain the health and wellbeing of the patient; and
- whether any alternative treatment is available and any significant risks of alternative treatment.

Applications to approve psychosurgery

Psychosurgery cannot be performed without the Tribunal's approval. With the Tribunal's approval, psychosurgery may be performed only on adults or children between the ages of 16 and 18 who consent to the treatment (s 208).

If a patient's psychiatrist recommends psychosurgery, the psychiatrist must complete an application form to ask the Tribunal for permission (s 417). The application must set out why the psychiatrist recommends psychosurgery and include a treatment plan.

The Tribunal cannot approve the psychosurgery unless satisfied that:

- the patient gives informed consent;
- the psychosurgery has clinical merit and is appropriate;
- all alternatives have been appropriately trialled but have not resulted in a sufficient and lasting benefit to the patient;
- the neurosurgeon is suitably qualified and experienced; and
- the proposed hospital is a suitable place.

In deciding whether to approve psychosurgery, the Tribunal must have regard to:

- the views of the patient's carers, close family members, or personal supporters;
- the consequences of not performing the psychosurgery;
- the nature and degree of the risks of the psychosurgery; and
- whether the psychosurgery will promote and maintain the health and wellbeing of the patient.

The Tribunal has not yet considered an application for psychosurgery.

Applications to issue compliance notices

Patients and other interested persons can complete an application form to ask the Tribunal to issue a *service provider* with a *compliance notice* for non-compliance with a *prescribed requirement* of the Act (s 423).

A 'service provider' is the person required by the Act to comply with a 'prescribed requirement' (s 422).

A 'prescribed requirement' is a requirement under the Act to:

- give a document or provide information to someone, or include a document or information on a patient's medical record, or comply with a request; or
- ensure a patient's treatment, support and discharge plan is prepared, reviewed or revised (s 422).

If after the hearing the Tribunal thinks the service provider has not complied with the prescribed requirement, the Tribunal may issue a compliance notice. The compliance notice may direct the service provider to:

- act within a set period to comply with the prescribed requirement; and
- report to the Tribunal about the outcome.

Before deciding to issue a compliance notice, the Tribunal must consider whether to refer the matter to one or more of the following:

- the Mental Health Commissioner;
- the Director General of the Health Department;
- the Chief Psychiatrist; or
- a registration board (s 423).

The President of the Tribunal must include in the Annual Report the name of each service provider issued with a compliance notice during that year; and the number of compliance notices issued during that year.

During 2019/20, the Tribunal did not issue any compliance notices. However, the Tribunal issued 18 recommendations to psychiatrists to review a patient's treatment support and discharge plan (TSDP) to ensure the TSDP fully complied with the Act and the Chief Psychiatrist's guidelines.

Section 423 arises most frequently around TSDPs. To facilitate greater compliance with TSDPs, before every periodic review the Tribunal writes to the responsible practitioner or case manager asking for an updated and compliant TSDP (one that complies with both the Act and the Chief Psychiatrist's Guidelines). The Tribunal attaches a copy of the Chief Psychiatrist's Guidelines to its request. The Tribunal also asks that the treating teams send a copy of the TSDP to the patient and the Tribunal at least three days before the hearing date.

Applications to review orders restricting a patient's freedom of communication

Section 261 of the Act provides that patients have the right of freedom of lawful communication, including the freedom to:

- see and speak with other people in the hospital;
- have uncensored communications with people, including visits, telephone calls, mail and electronic communications; and
- receive visits and other contact from legal practitioners, mental health advocates and others.

Nevertheless, in certain circumstances a psychiatrist may make an order limiting or preventing the exercise of these rights (s 262). These orders must be in the approved form, placed on the patient's file, and a copy given to the patient and personal supporters.

Patients and other interested persons can complete an application form to ask the Tribunal to review a psychiatrist's order limiting or preventing exercise of these rights (s 427). After completing the hearing, the Tribunal can confirm, amend, or revoke the psychiatrist's order.

Applications to resolve certain questions arising in respect of nominated persons

Patients may nominate a person to assist them to ensure their rights are observed, and their wishes and interests are considered. Patients and other interested persons can complete an application form to ask the Tribunal to make declarations about the validity of a nomination, or to revoke a nomination (s 430).

On an application for a declaration about validity, the Tribunal may declare that a nomination is valid or invalid. The Tribunal may also vary the terms of the nomination to give effect to the intention of nomination (s 431).

On an application to revoke a nomination, the Tribunal may revoke a nomination if satisfied that the nominated person is not appropriate because they are:

- likely to adversely affect the interests of the patient; or
- not capable of performing that role because of mental or physical incapacity; or
- not willing or able to perform the role (s 432).

Applications to review any other decision affecting a patient's rights

Patients and other interested persons can complete an application form to ask the Tribunal to review other decisions made under the Act that affect a person's rights and that cannot be heard by the Tribunal under another provision (s 434).

On completing the review, the Tribunal may make any orders, and give any directions, the Tribunal considers appropriate.

Determinations, orders, and reasons for decision

At the end of each hearing, the Tribunal tells the participants its decision, and the reasons for its decision. Tribunal members provide parties with oral reasons which contain enough information for the parties to understand (although not necessarily accept) the outcome. The reasons need to be in terms the patient is likely to understand. However, the reasons must also have enough detail to identify, for the State Administrative Tribunal (SAT), the factual and legal basis for the decision and the Tribunal's reasoning.

The Tribunal sends a Notice of Decision to the parties by post or email shortly after the hearing. This is the Tribunal's formal order arising from the hearing. The Tribunal's order informs the party of the right to seek reasons for Tribunal's decision, and the right to apply to the SAT for a review of the Tribunal's decision. Parties who request reasons are given a transcript of the oral reasons provided at the hearing. The Tribunal does not otherwise provide written reasons for decision unless the member has not provided adequate oral reasons at the hearing. Such matters are referred to the President for further action.

Review by the State Administrative Tribunal

Decisions of the Tribunal are reviewable by the SAT. Such matters fall within the SAT's review jurisdiction and are conducted by way of a hearing *de novo*. In other words, the SAT is not confined to matters that were before the Tribunal and may consider new material whether it existed at the time of the Tribunal hearing. The purpose of the SAT's review is to produce the correct and preferable decision at the time of the decision upon review.

The SAT may affirm the Tribunal's decision, vary the Tribunal's decision, or set aside the Tribunal's decision, and either substitute its own decision or send the matter back to the Tribunal for reconsideration.

A decision to revoke or set aside a decision of the Tribunal does not necessarily indicate an error in the Tribunal's original decision. This is because the SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing.

Performance and Statistics

What we measure

We measure the number of hearings we list each year (hearings listed) as well as the number of hearings conducted (hearings conducted). We measure both because in about one-third of matters, the psychiatrist will revoke the involuntary treatment order a few days or hours before the hearing. When this happens, the patient no longer requires the hearing and we must discontinue it.

In many cases, the Tribunal cannot fill this vacancy with another hearing because it cannot give the participants enough notice to attend. In these circumstances, the Tribunal has used its resources to list and prepare for the hearings which proceeded as well as those which were discontinued. These resources are reflected in, and accounted for by, the number of hearings listed.

There is no reliable way to predict which orders will be revoked and which will proceed to hearing. The nature of the Tribunal's hearings means the Tribunal cannot fully address the issue by 'over-listing' or by using 'rolling lists' such as those used by Magistrates Courts. This is an issue which is common to Mental Health Tribunals in other states, which also report on both hearings listed and hearings conducted.

Hearing numbers

In 2019/20, the Tribunal listed 4,253 hearings, an increase of 635 (17.5%) from 2018/19. This is an overall increase of 28.1% since 2016/17. Of the 4,253 hearings listed in 2019/20, 2,627 (61.8%) proceeded to a hearing.

Figure 1: 2019/20 hearings listed vs hearings conducted

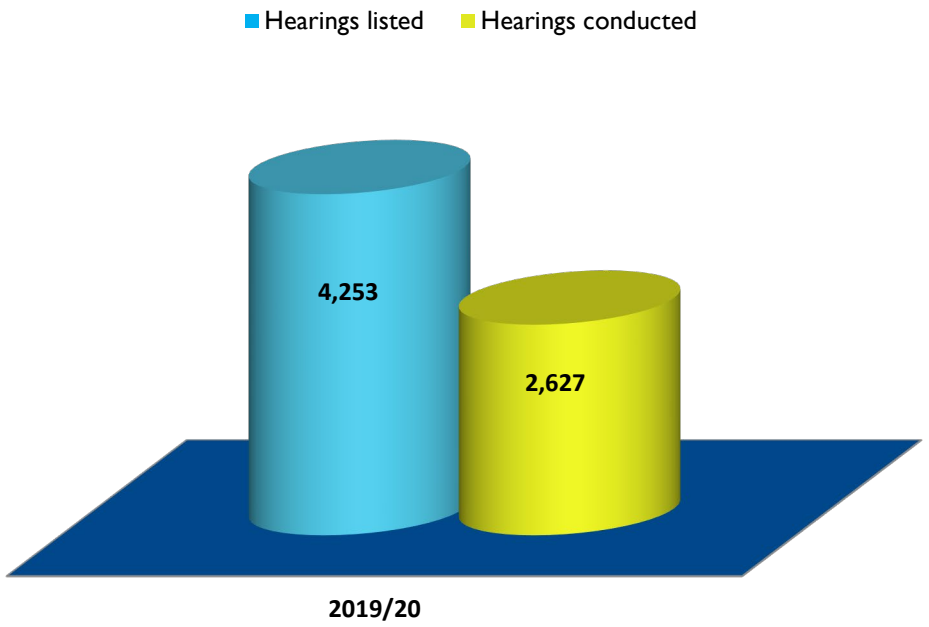


Figure 2: Yearly comparison of hearings listed vs hearings conducted

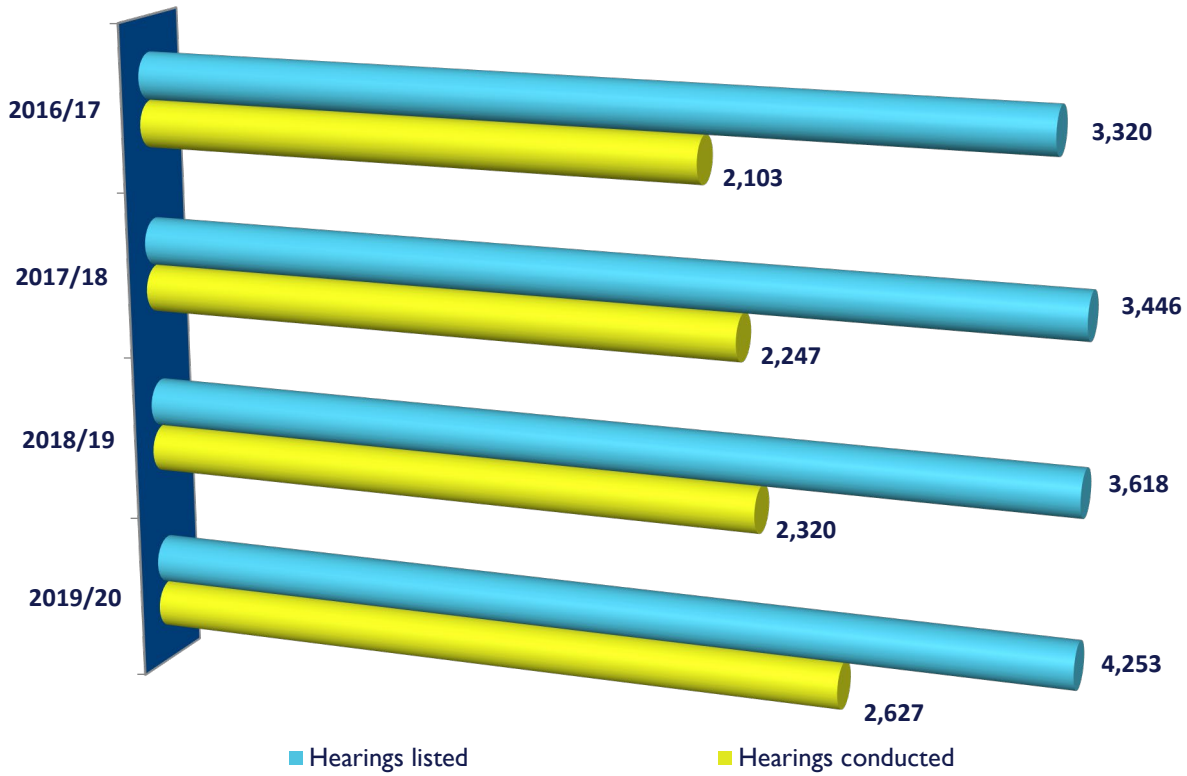
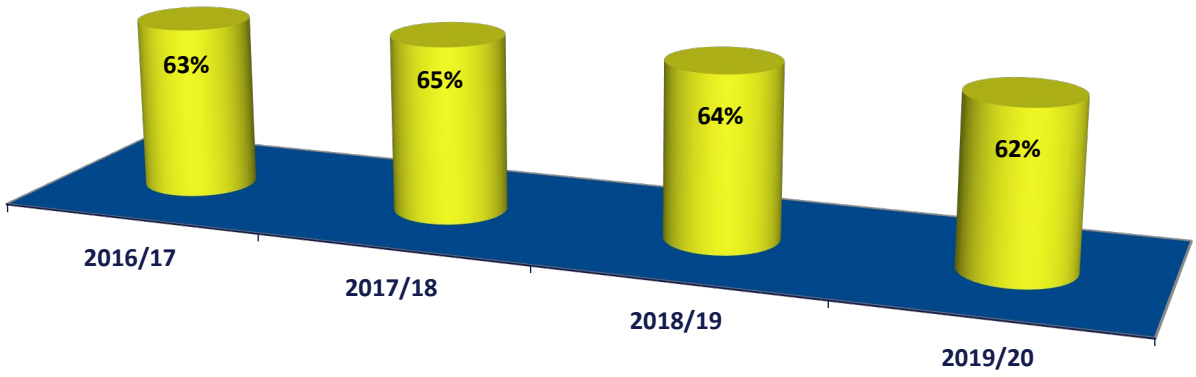


Figure 3: Yearly comparison of percentage of hearings conducted



Hearings conducted by matter types

In 2019/20, the Tribunal conducted 2,627 hearings. Of these, 1,082 (41.2%) were initial review hearings conducted pursuant to section 386 of the Act. A further 1,356 (51.6%) were periodic review hearings conducted pursuant to section 387 of the Act. The balance of 189 (7.2%) were applications made to the Tribunal by patients or psychiatrists.

Figure 4: 2019/20 percentage of hearings conducted by matter type

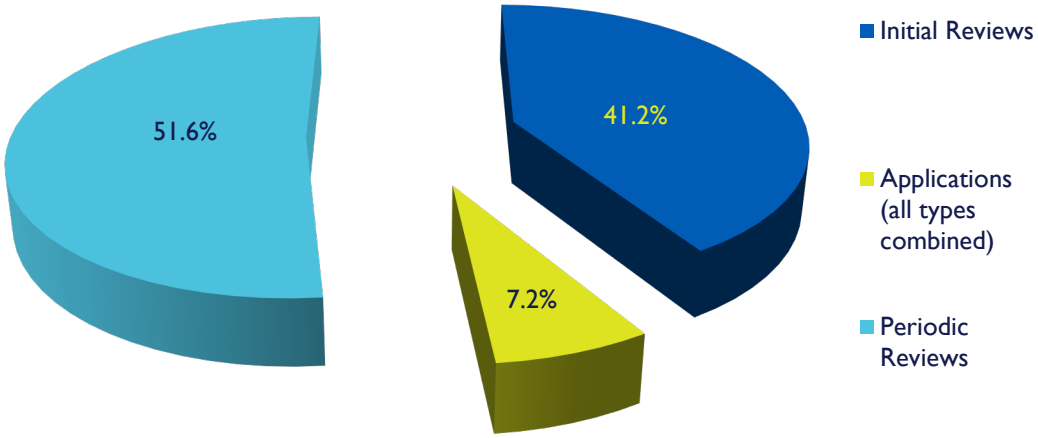
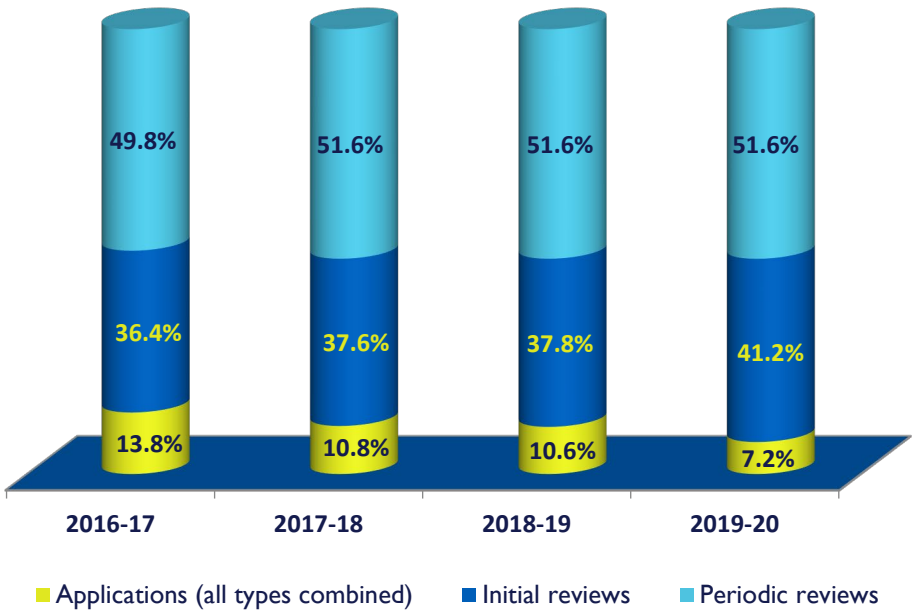


Figure 5: Yearly comparison of percentage of hearings conducted by matter type

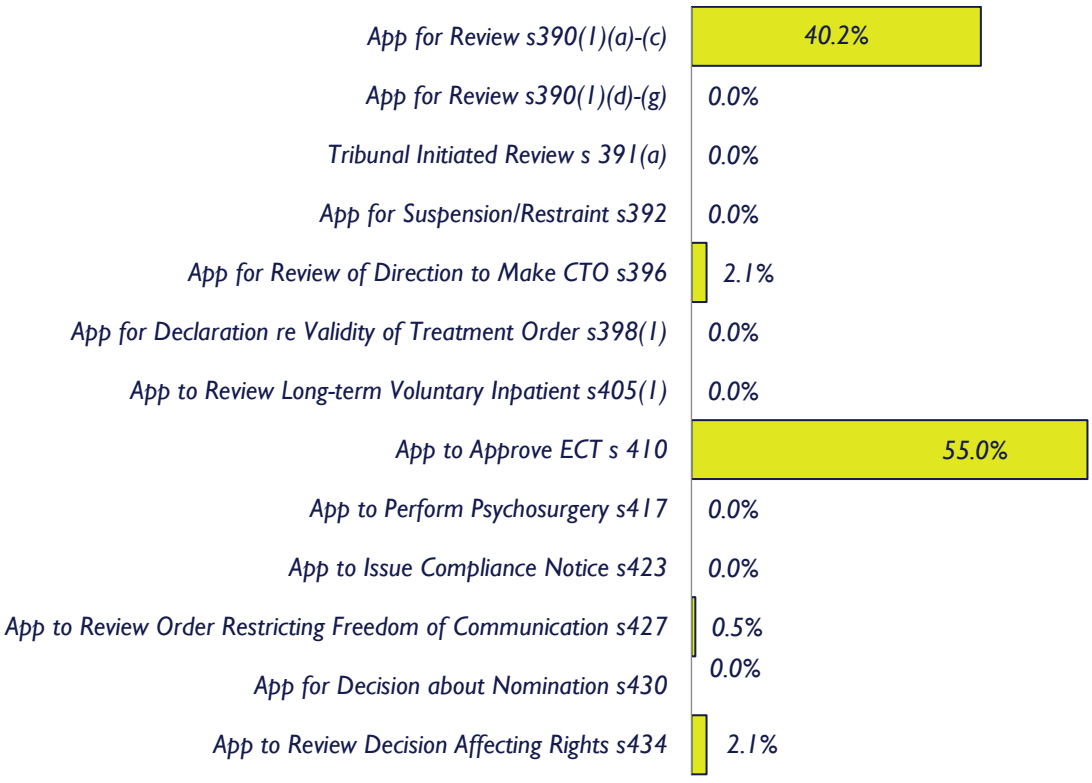


The Tribunal's case management system ICMS remains configured for the 1996 Act. Accordingly, it records all the applications made under sections 390 – 434 of the Act as 'requested reviews'. Consequently, ICMS cannot break down the numbers of each type of application heard by the Tribunal. The Tribunal's requests for funding to purchase a new case management system have not been granted.

Considering the importance of this information, during 2019/20 the Tribunal resorted to manually collecting certain statistics which cannot be obtained from ICMS. For the first time since the commencement of the Act in 2015, the Tribunal can report in detail on how many applications were made under sections 390 – 434 of the Act during the financial year, and the outcomes of those applications.

As demonstrated in Figure 6, 55% of the 189 applications made to the Tribunal were applications by a patient's psychiatrist seeking approval to perform electroconvulsive therapy on the patient pursuant to section 410 of the Act. A further 40% were applications made by (or on behalf of) patients to review an involuntary treatment order pursuant to section 390(1)(a)-(c) of the Act.

Figure 6: 2019/20 types of applications made (as a percentage of total applications)



Many application types are not widely used. The Tribunal continues to promote the range of application options available to patients through its website and through liaison with the Mental Health Advocacy Service (MHAS) and the Mental Health Law Centre (MHLC).

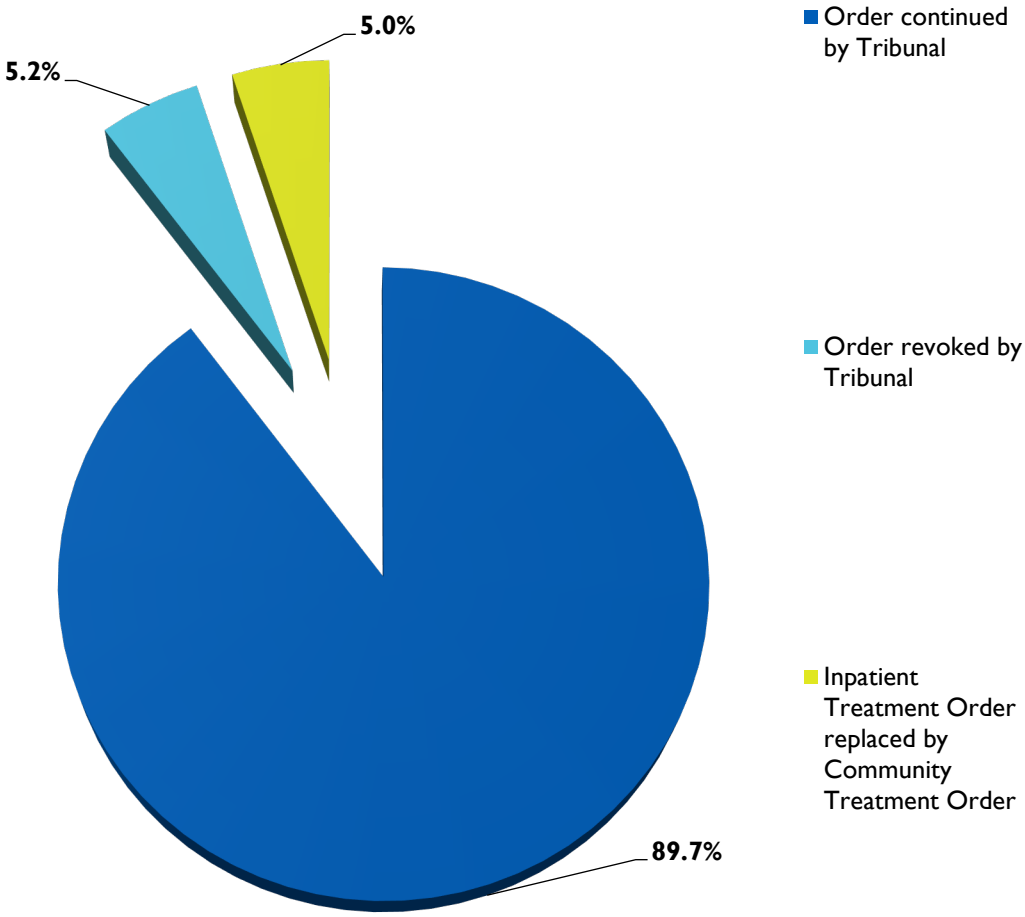
Hearings completed by outcome

Because of the Tribunal's new process of manually recording hearing outcomes, for the first time the Tribunal can report in detail on the outcomes of the different types of hearings completed by the Tribunal.

2019/20 Initial review hearing outcomes (s 386)

Of the 1,082 initial review hearings conducted in 2019/20, 186 hearings were adjourned or vacated at the hearing (adjournments are discussed separately). The remaining 896 hearings were completed. Of those completed, in 804 matters (89.7%) the Tribunal was satisfied that the involuntary patient remained in need of the involuntary treatment order and continued the order. In 47 matters (5.2%) the Tribunal was not satisfied the involuntary patient remained in need of the involuntary treatment order and revoked the order. In 45 matters (5%) the Tribunal was not satisfied the involuntary patient remained in need of an inpatient treatment order and directed the psychiatrist to issue a community treatment order instead.

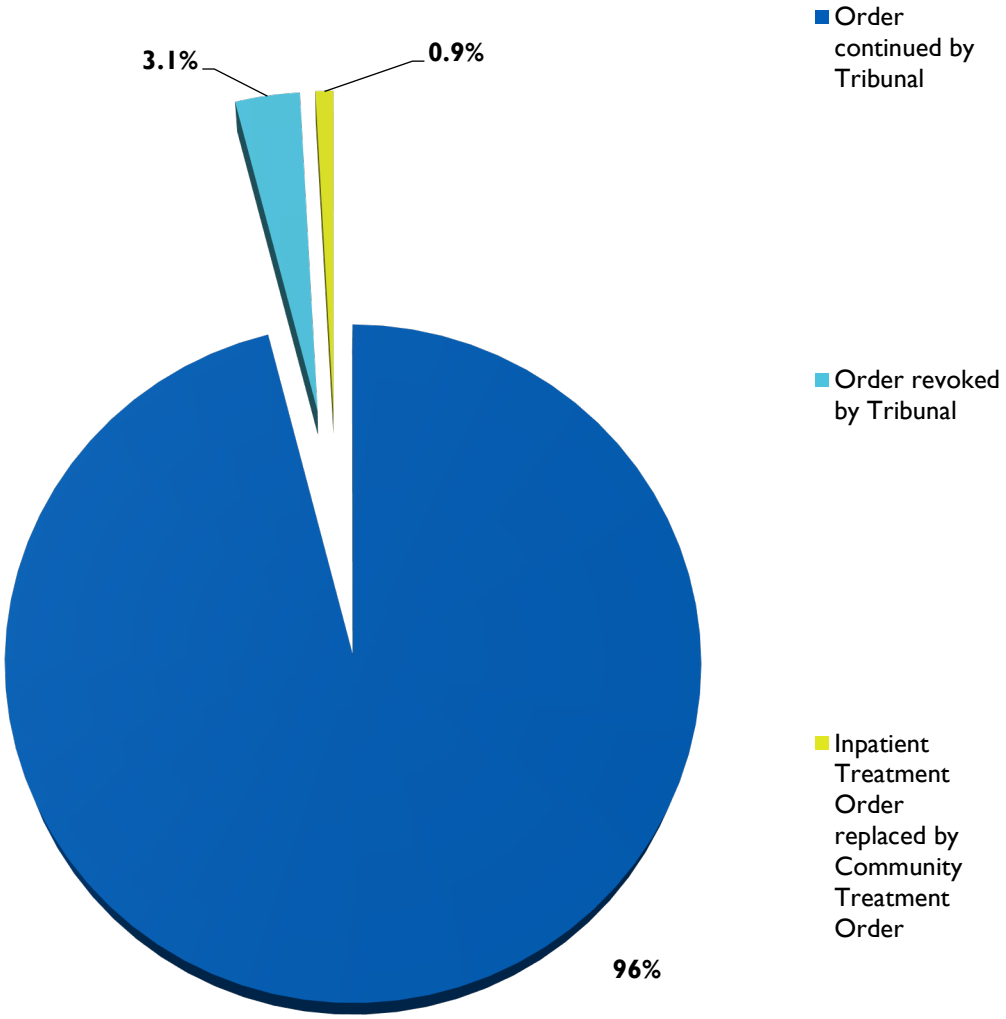
Figure 7: 2019/20 outcomes of initial review hearings as a percentage of completed matters



2019/20 Periodic review hearing outcomes (s 387)

Of the 1,356 periodic review hearings conducted in 2019/20, 205 hearings were adjourned or vacated at the hearing (adjournments are discussed separately). The remaining 1,151 hearings were completed. Of those completed, in 1,105 matters (96%) the Tribunal was satisfied that the involuntary patient remained in need of the involuntary treatment order and continued the order. In 36 matters (3.1%) the Tribunal was not satisfied the involuntary patient remained in need of the involuntary treatment order and revoked the order. In 10 matters (0.9%) the Tribunal was not satisfied the involuntary patient remained in need of an inpatient treatment order and directed the psychiatrist to issue a community treatment order instead.

Figure 8: 2019/20 outcomes of periodic review hearings as a percentage of completed matters



2019/20 Initial and periodic review hearing outcomes combined

In previous years, the Tribunal has reported on initial and periodic review hearings combined. We will continue to do so for comparative purposes.

Figure 9: 2019/20 outcomes of initial and periodic review hearings (combined) as a percentage of completed matters

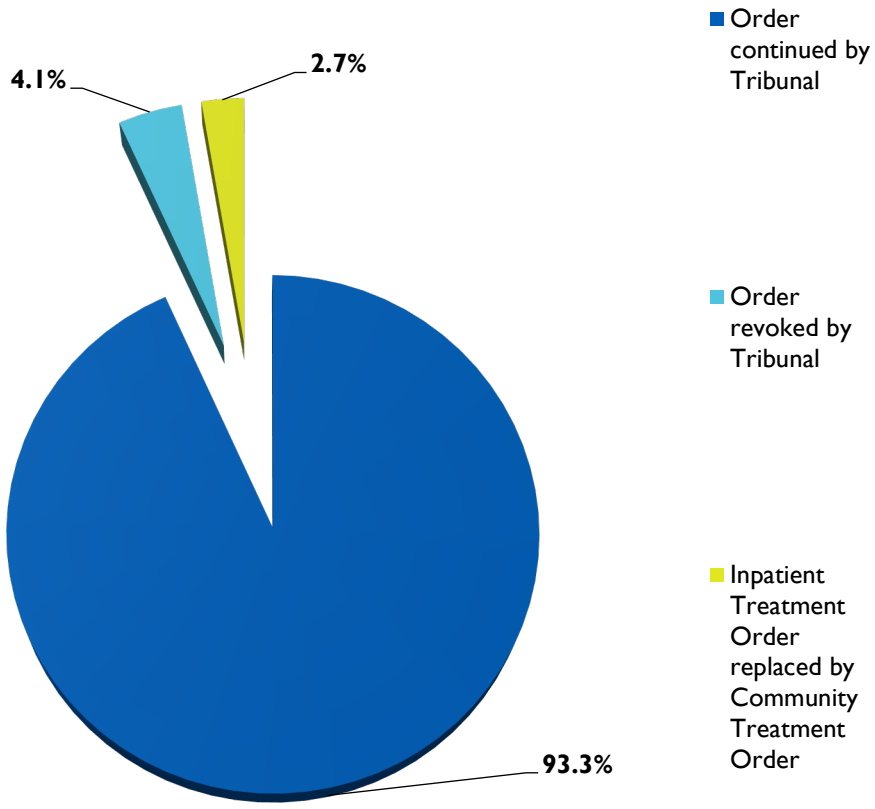
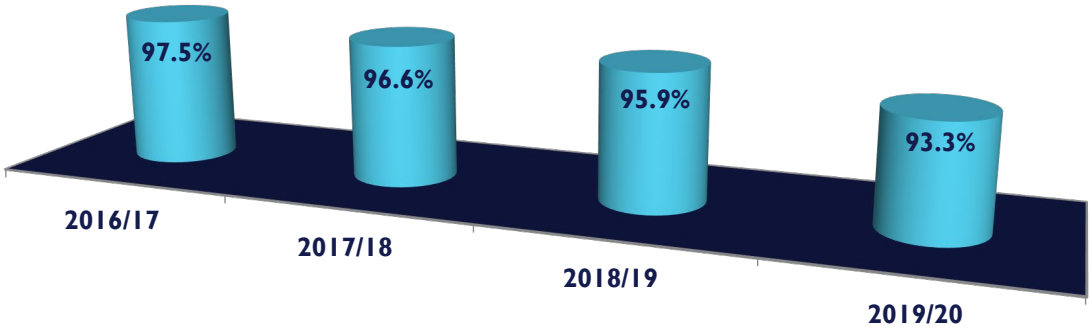


Figure 10: Yearly comparison of outcomes of initial and periodic review hearings (combined) as a percentage of completed matters

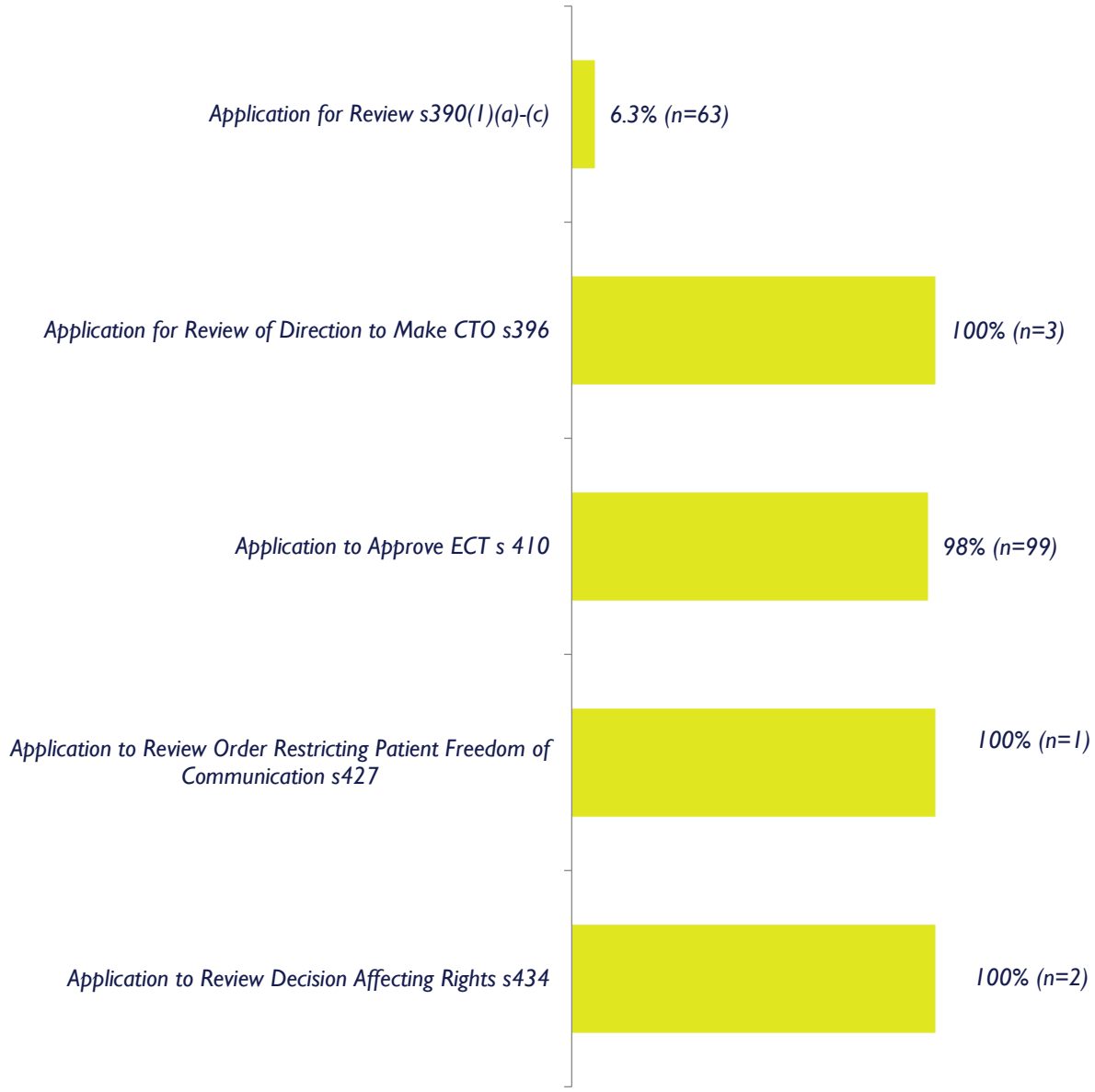


Applications made under sections 390 – 434 of the Act: 'successful' applications by type

Applications to the Tribunal pursuant to sections 390 – 434 of the Act may be made by a range of interested persons, such as the psychiatrist, the patient, or in some cases a third party. For the purposes of reporting, an application is 'successful' if the Tribunal grants orders in favour of the applicant. Accordingly, a 'successful application' is not necessarily one that is decided in favour of the patient.

Because of the small numbers of some types of applications, the total number of completed applications for each type of hearing is identified in the label.

Figure 11: 2019/20 'successful' applications as a percentage of number of completed applications of that type



Adjournments

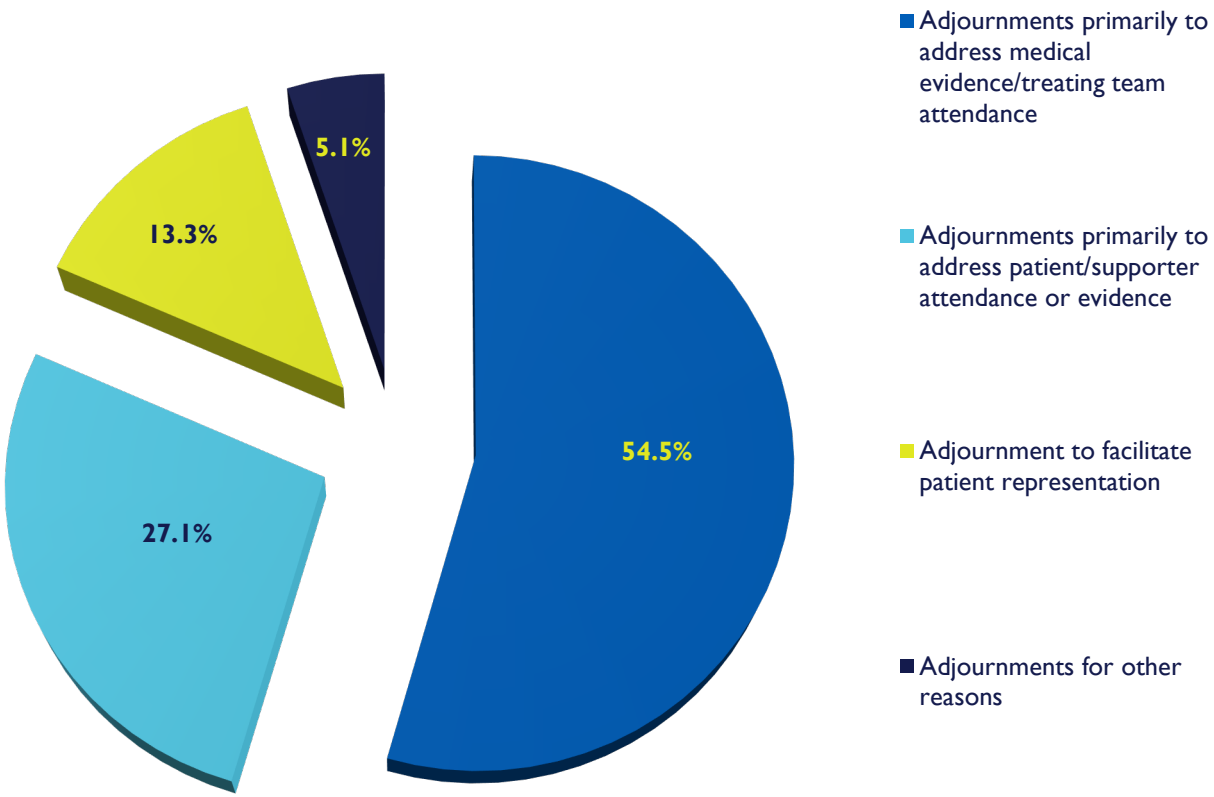
Out of the 2,627 hearings conducted during 2019/20, 391 (15%) were adjourned at the hearing.

Adjournments are distressing and inconvenient for patients and their supporters, and a significant waste of public resources for hospitals, treating teams, the MHAS, the MHLC, and the Tribunal. Accordingly, the Tribunal generally will not adjourn a hearing except where necessary to ensure procedural fairness or to obtain further evidence.

The reasons for an adjournment generally fall into one of four categories:

- adjournments primarily to ensure the Tribunal receives adequate medical evidence or to permit the attendance of the treating psychiatrist or other key medical witness;
- adjournments primarily to permit the attendance of the patient, a key supporter or a lay witness;
- adjournments to facilitate the patient receiving advice and/or representation by the MHAS or the MHLC; or
- adjournments for any other reason (this year, these were primarily technological issues arising during videoconferences necessitated by COVID-19).

Figure 12: 2019/20 reasons for adjournment as a percentage of all adjournments

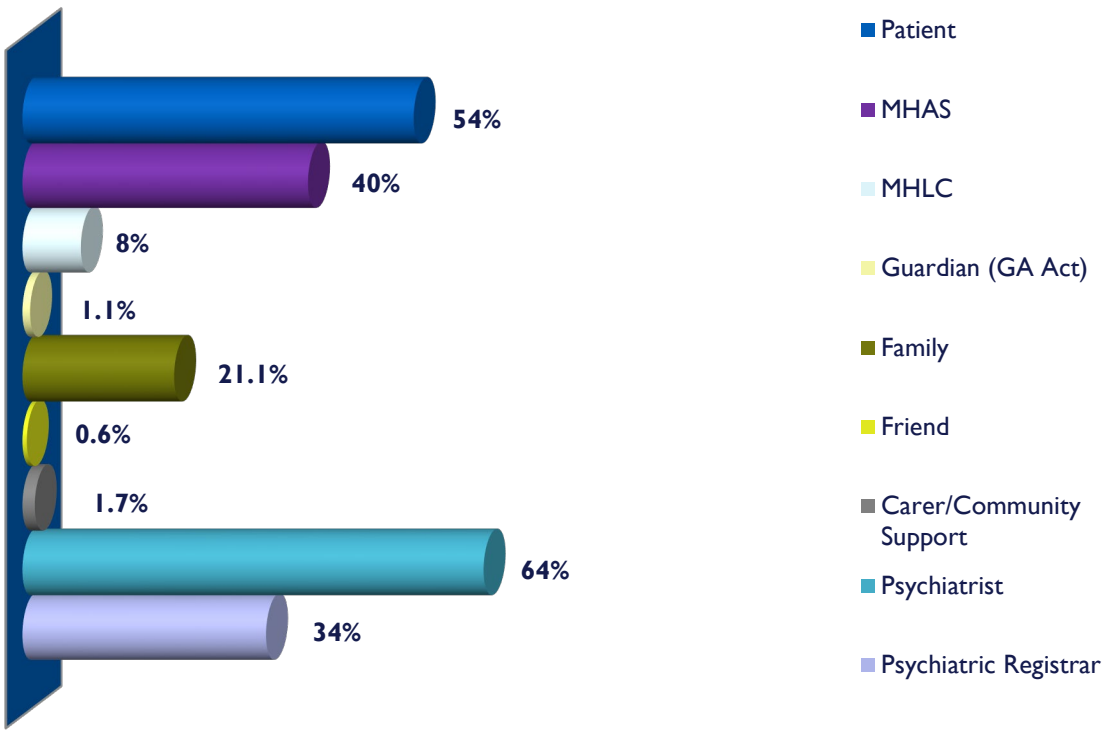


Most adjournments (55%) are primarily to address the adequacy of medical evidence or the attendance of members of the treating team. The President is liaising with the executives and clinical leads of each statutory health service provider to find ways to address this issue. The Registrar is also exploring supplemental options for hearing notification (such as email and sms reminders) and alternative means of attendance (such as secure online meeting rooms) to reduce adjournments primarily to address patient or supporter attendance.

Attendance at hearings

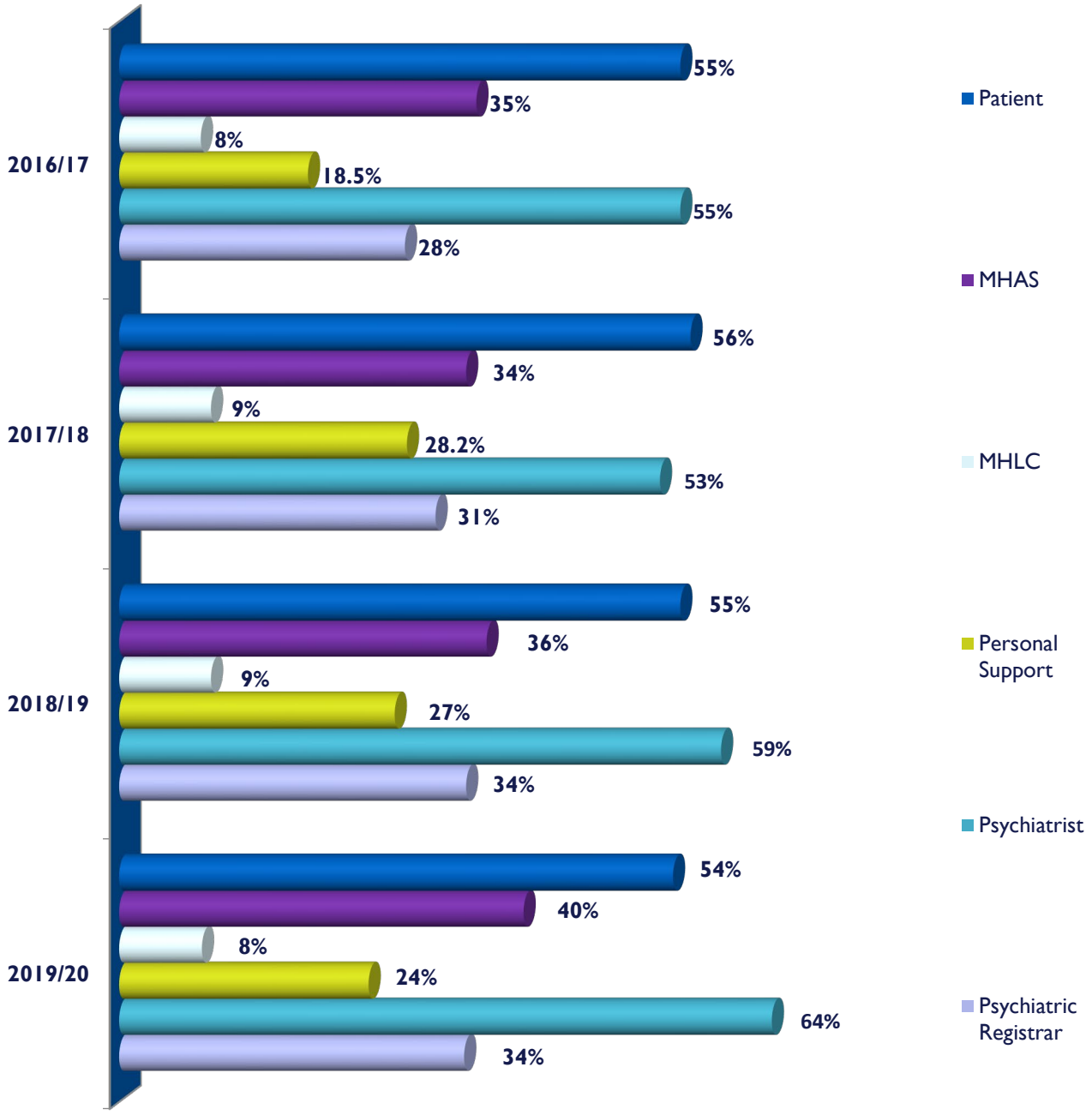
In 2019/20, the Tribunal conducted 2,627 hearings. Patients attended their own hearings 54% of the time. Patients were represented by the MHAS at 40% of hearings. Patients were represented by the MHLC at 8% of hearings. Patients had Guardians (appointed under the *Guardianship and Administration Act 1990* (WA) (GA Act)) present at 1.1% of hearings, and family members present at 21.1% of hearings. Patients attended the hearing with a friend at 0.6% of hearings and a carer at 1.7% of hearings. Psychiatrists attended 64% of hearings, and psychiatric registrars attended at 34% of hearings (either with a psychiatrist or alone).

Figure 13: 2019/20 frequency of hearing attendance by participant type



Note: multiple parties attend most hearings, and percentage of total attendees will exceed 100%.

Figure 14: Yearly comparison of frequency of hearing attendance by participant type



Note: multiple parties attend most hearings, and percentage of total attendees will exceed 100%. In 2016/17, separate figures for attendance by Guardians, Family, Friends, and Carer/Community support were not reported. As all four categories were combined, direct comparisons are not available for these categories. For the purposes of comparison between 2016/17 and future years, a combined category of 'Personal Support' has been used.

As demonstrated in Figure 14, there was a further small increase in participation by psychiatrists in 2019/20. There was also an increase in participation by the MHAS in 2019/20, and a small decrease in participation by personal supporters. Participation rates have otherwise been relatively consistent since 2016.

Hearing mode

In 2019/20, the Tribunal conducted 1,474 of its 2,627 hearings (56%) in-person at a health service. The Tribunal conducted 1,153 hearings by videoconference (44%). Videoconference hearings significantly increased during 2019/20 because the Tribunal ceased in-person hearings during the COVID-19 pandemic. Commencing 1 April 2020, every hearing was conducted by videoconference.

Figure 15: 2019/20 hearing mode

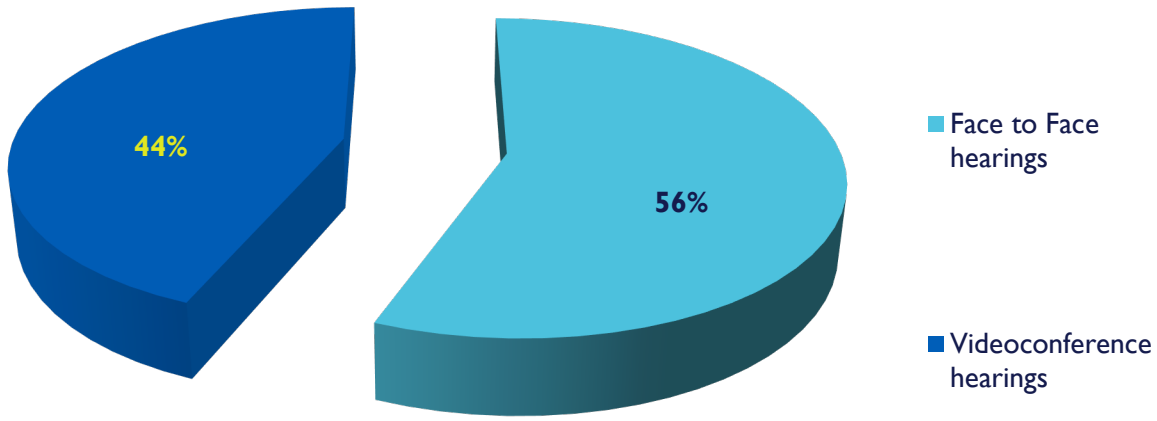
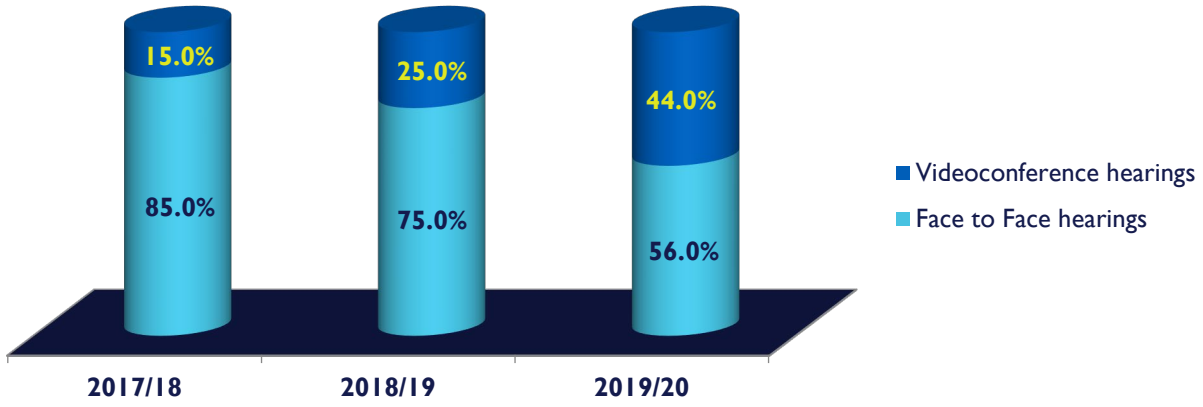


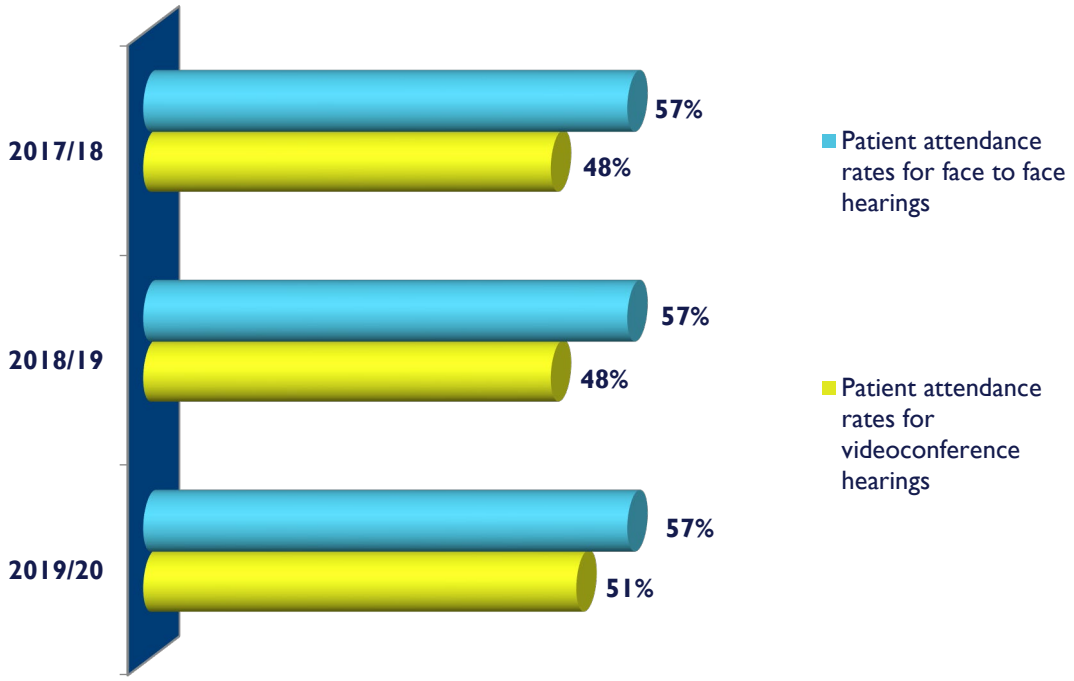
Figure 16: Comparison of hearing mode by year



Note: data for previous years is not available

In 2019/20, patients attended in-person hearings at a rate of 57% and attended videoconference hearings at a rate of 51%. As demonstrated by Figure 17, patient attendance at videoconference hearings increased in 2019/20, and patient attendance at in-person hearings remained constant.

Figure 17: Yearly comparison of patient attendance at hearings by hearing mode

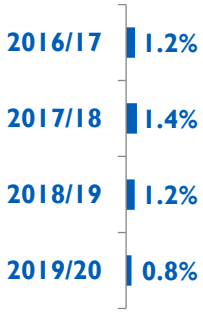


Note: data for previous years is not available

Requests for written reasons for decisions

Patients request written reasons for the Tribunal's decision in only a small percentage of hearings. In 2019/20, the Tribunal provided a written transcript of the reasons for decision on request in 20 out of 2,627 matters (0.8%). This compares with 1.2% in 2018/19, 1.4% in 2017/18 and 1.2% in 2016/17.

Figure 18: Comparison of percentage of requests for written reasons for decision by year



Review by the State Administrative Tribunal

Decisions of the Tribunal are reviewable by the SAT.

The SAT may affirm the Tribunal's decision, vary the Tribunal's decision, or set aside the Tribunal's decision, and either substitute its own decision or send the matter back to the Tribunal for reconsideration.

Because the SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing, a decision by the SAT to revoke or set aside a decision of the Tribunal does not necessarily indicate an error on the part of the Tribunal in deciding the matter.

Starting this year, the Tribunal is changing how it reports the number and outcome of applications for review by the SAT. The purpose of this change it to improve the clarity and accuracy of the Tribunal's reporting.

The Tribunal will count and report on the following matters:

- the number of Tribunal decisions which are the subject of an application to the SAT for review under section 494 of the Act during the current financial year. This number will also be compared with previous years. The reporting year for *applications made* will be determined by the date of lodgement (see Figure 19).
- the outcome of the applications made during the current financial year, to the extent that those matters are resolved (see Figure 20); and
- the number of applications determined by the SAT in each financial year. The reporting year for *applications determined* will be the date of decision (see Figure 21).

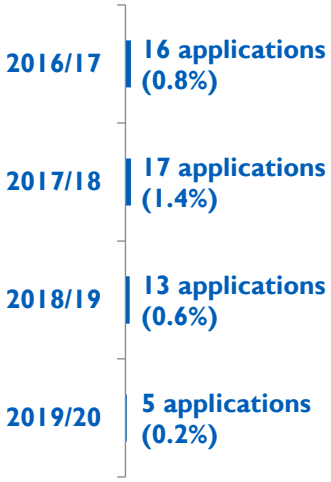
This means that the number of *applications made* in a financial year will not necessarily equal the number of *applications determined* in a financial year. Some applications are made in one financial year and determined by the SAT in the next.

All data reported in this report has been recounted using the new methodology (including data from earlier financial years). In previous annual reports, the reporting year for *applications made* and *applications determined* were not clearly articulated, resulting in ambiguity.

Number of applications for review made to the State Administrative Tribunal in 2019-20

In 2019/20, only five out of 2,627 Tribunal decisions (0.2%) were the subject of an application to the SAT for review under section 494 of the Act. As shown in Figure 19, this number has decreased significantly since 2016/17.

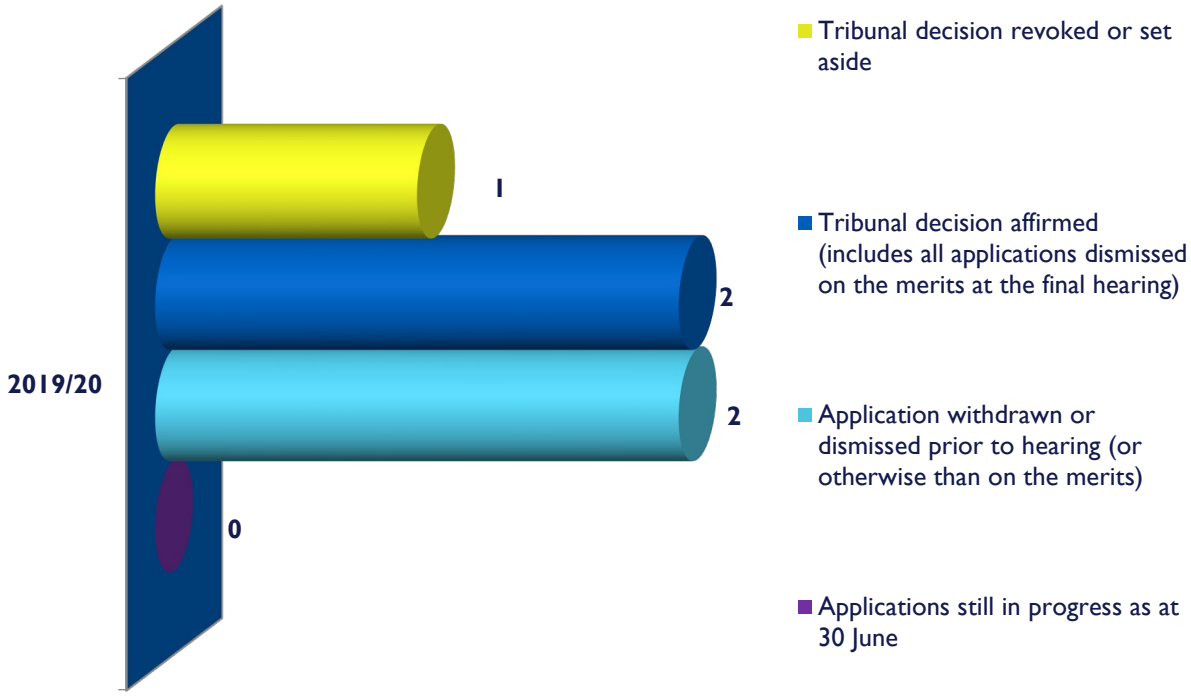
Figure 19: Comparison of number and percentage of review applications made to the State Administrative Tribunal during each financial year



Outcome of applications for review made to the State Administrative Tribunal in 2019/20

In 2019/20, all five of the applications made to the SAT were resolved before the end of the financial year. The SAT revoked the Tribunal's decision in one matter, affirmed the Tribunal's decision in two matters, and two matters were withdrawn or dismissed prior to hearing.

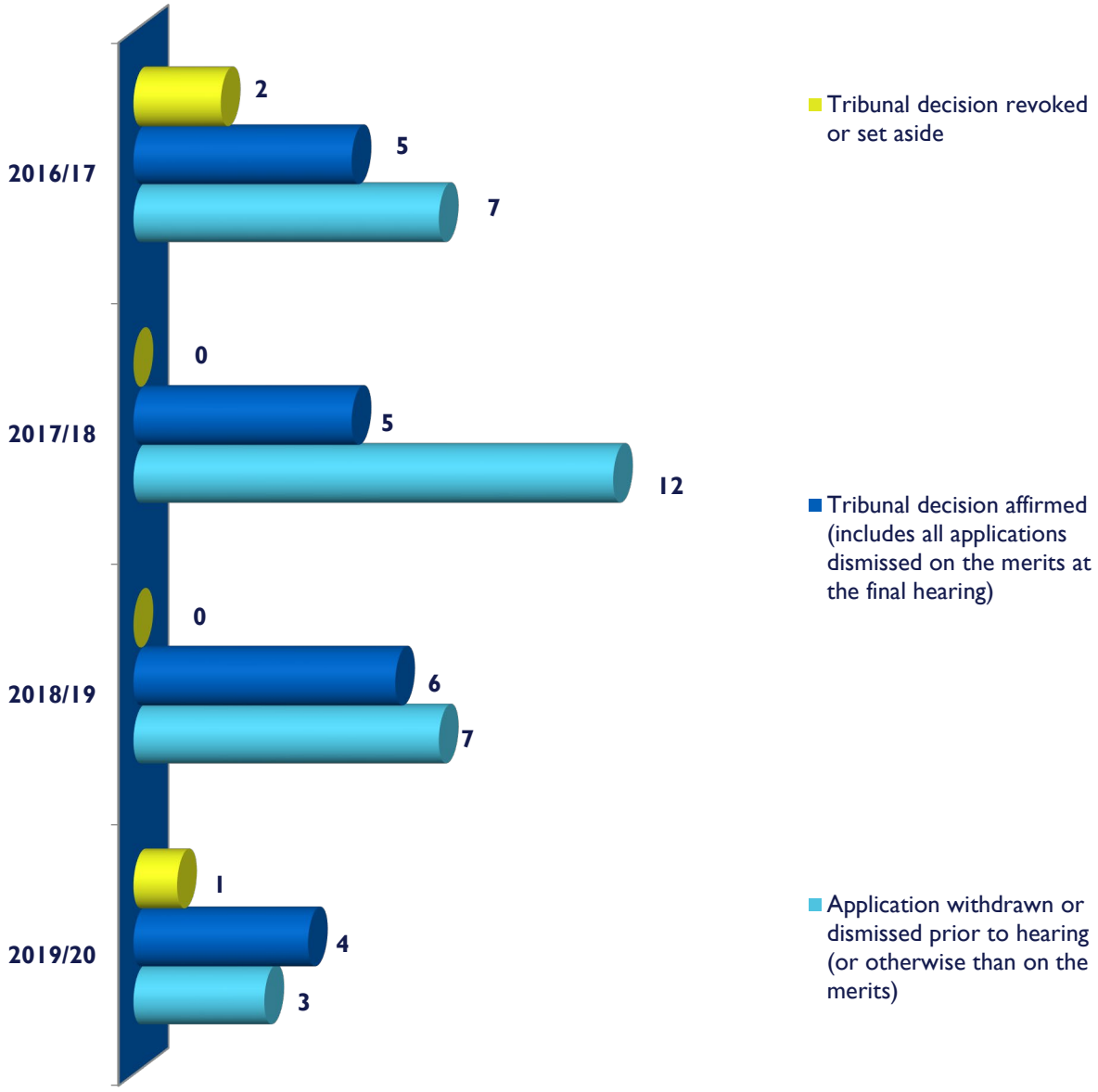
Figure 20: Outcome of applications for review made to the SAT during 2019/20



Outcome of all applications for review determined by the State Administrative Tribunal by financial year determined

The SAT determines matters based on the evidence available at the date of its hearing, rather than the materials before the Tribunal at the original hearing. For this reason, the SAT's decision to revoke or set aside a decision of the Tribunal does not necessarily indicate an error on the part of the Tribunal in deciding the matter.

Figure 21: Outcome of all applications for review determined by the State Administrative Tribunal by financial year determined



Financial Report

In 2019/20, the Tribunal was funded by Parliamentary appropriation of $2.67M.

The Tribunal is an affiliated body of the Mental Health Commission within the meaning of section 60(1)(b) of the *Financial Management Act 2006* (WA). The Tribunal's Parliamentary appropriation is paid directly to, and administered by, the Mental Health Commission.

The Mental Health Commission includes in its Annual Report a financial statement for the Tribunal.

Appendix One: Tribunal Members at 30 June 2020

Legal Members

Tribunal Member Name	Type	Commencement of Current Term	Expiry of Current Term
Karen Whitney	President	30 December 2017	29 December 2022
Jeanette De Klerk	Full-time	29 October 2019	28 October 2024
Camille Woodward	Full-time	1 February 2020	31 January 2025
Peter Curry	Part-time	29 October 2019	28 October 2024
Christine Kannis	Part-time	29 October 2019	28 October 2024
Dr Hannah McGlade	Part-time	29 October 2019	28 October 2024
Her Honour Catherine 'Kate' O'Brien	Part-time	29 October 2019	28 October 2024
Harriette Benz	Sessional	2 May 2017	1 May 2022
Nicola Findson	Sessional	29 October 2019	28 October 2024
Andrea McCallum	Sessional	2 May 2017	1 May 2022
Michael Nicholls QC	Sessional	2 May 2017	1 May 2022
Anne Seghezzi	Sessional	2 May 2017	1 May 2022
Merranie Strauss	Sessional	2 May 2017	1 May 2022
Jennifer Wall	Sessional	29 October 2019	28 October 2024

Psychiatrist Members

Tribunal Member Name	Type	Commencement of Current Term	Expiry of Current Term
Dr Dawn Barker	Sessional	1 May 2018	30 April 2023
Dr Ann Bell	Sessional	1 May 2018	30 April 2023
Dr Nadine Caunt	Sessional	29 October 2019	28 October 2024
Dr Emma Crampin	Sessional	1 May 2018	30 April 2023
Dr Rowan Davidson	Sessional	20 December 2016	19 December 2021
Dr Daniel De Klerk	Sessional	1 May 2018	30 April 2023
Dr Kevin Dodd	Sessional	2 May 2017	1 May 2022
Dr David Lord	Sessional	20 December 2016	19 December 2021
Dr Mircea Schineanu	Sessional	1 May 2018	30 April 2023
Dr Bryan Tanney	Sessional	2 May 2017	1 May 2022
Dr Kavitha Vijayalakshmi	Sessional	29 October 2019	28 October 2024
Dr Helen Ward	Sessional	1 May 2018	30 April 2023
Dr Anthony Zorbas	Sessional	2 May 2017	1 May 2022

Community Members

Tribunal Member Name	Type	Commencement of Current Term	Expiry of Current Term
Teresa 'Ted' Ellis	Full-time	29 October 2019	28 October 2024
Dr Michael 'Lenney' Lenney	Full-time	29 October 2019	28 October 2024
Manjit Kaur	Part-time	29 October 2019	28 October 2024
The Hon. Keith Wilson AM	Part-time	29 October 2019	28 October 2024
Alan Alford	Sessional	2 May 2017	1 May 2022
Jennifer Bridge-Wright	Sessional	2 May 2017	1 May 2022
Reverend Rodger Bull	Sessional	2 May 2017	1 May 2022
Donna Dean	Sessional	2 May 2017	1 May 2022
Stuart Flynn	Sessional	2 May 2017	1 May 2022
John Gardiner	Sessional	2 May 2017	1 May 2022
Susan Grace	Sessional	2 May 2017	1 May 2022
Emeritus Prof. David Hawks AM	Sessional	2 May 2017	1 May 2022
John James	Sessional	2 May 2017	1 May 2022
Lorrae Loud	Sessional	20 December 2016	19 December 2021
David Rowell	Sessional	2 May 2017	1 May 2022
Leone Shiels	Sessional	2 May 2017	1 May 2022
Anthony Warner AM LVO	Sessional	2 May 2017	1 May 2022
Ann White	Sessional	2 May 2017	1 May 2022

Inactive Members

Members become inactive if they are not available for hearings because of extended leave, ongoing potential conflicts of interest, or other extended unavailability.

Tribunal Member Name	Type	Commencement of Current Term	Expiry of Current Term
Geoffrey Abbott	*Sessional Legal*	*20 December 2016*	*19 December 2021*
Kathryn Barker	*Sessional Legal*	*2 May 2017*	*1 May 2022*
Dr Lynne Cunningham	*Sessional Psychiatrist*	*29 October 2019*	*28 October 2024*
Dr Paul O'Hara	*Sessional Psychiatrist*	*29 October 2019*	*28 October 2024*
Dr Alexksandra Jaworska	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*
Dr Sally Kelderman	*Sessional Psychiatrist*	*29 October 2019*	*28 October 2024*
Dr Fiona Krantz	*Sessional Psychiatrist*	*1 May 2018*	*30 April 2023*
Dr Roland Main	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*
Dr Helen Milroy	*Sessional Psychiatrist*	*29 October 2019*	*28 October 2024*
Dr Elizabeth Moore	*Sessional Psychiatrist*	*1 May 2018*	*30 April 2023*
Dr Ahmed Munib	*Sessional Psychiatrist*	*1 May 2018*	*30 April 2023*

Dr Steven Patchett	*Sessional Psychiatrist*	*2 May 2017*	*1 May 2022*
Dr Gordon Shymko	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*
Dr Helen Slattery	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*
Dr Alexander Tait	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*
Dr Gabor Ungvari	*Sessional Psychiatrist*	*20 December 2016*	*19 December 2021*

Appendix Two: Strategic Plan 2018 – 2020

our vision

Accessible justice for those whose rights are affected by decisions made under the *Mental Health Act 2014*.

our mission

Safeguarding rights and promoting compliance and accountability under the *Mental Health Act 2014* by:

- Ensuring involuntary treatment authorised under the Act strictly complies with the provisions and objects of the Act;
- Determining applications for treatment by electroconvulsive therapy and psychosurgery;
- Addressing non-compliance with prescribed requirements under the Act; and
- Providing independent review of the validity of involuntary treatment orders, the admission of long-term voluntary patients, the validity and appropriateness of nominated persons, and the reasonableness of certain decisions under the Act restricting freedoms and affecting rights.

our values

- Respect for the law
- Equality before the law
- Fairness
- Impartiality
- Independence
- Accessibility
- Efficiency
- Accountability
- Competence
- Integrity

strategic objectives and action plan

We will achieve high quality patient-centred outcomes in every matter.

- The Tribunal will conduct a respectful, fair hearing resulting in a consistent, just decision in every matter by:
  - ✓ conducting hearings in accordance with the principles of procedural fairness;
  - ✓ deciding matters solely on the application of the relevant law to the facts of the case;
  - ✓ making factual findings based on an independent assessment of the quality and weight of the evidence presented, including the expert evidence;
  - ✓ interpreting the law consistently, impartially and independently;
  - ✓ treating everyone with fairness, courtesy, tolerance and compassion.
- The Tribunal will meet statutory objects, functions, obligations and timeframes in every matter by:
  - ✓ ensuring the Tribunal is validly constituted in every matter;
  - ✓ conducting every matter in accordance with the timeframes set out in the Act;
  - ✓ ensuring Tribunal proceedings, notices, orders and reasons are consistent with the Act;
  - ✓ having regard to the mandatory statutory factors required for each matter type;
  - ✓ ensuring Registry functions comply with the Act.

We will support stakeholder participation in the hearing process.	▪ The Tribunal will provide patients, carers, families and supporters with the information they need to actively participate in hearings. ▪ The President will make rules and or publish practice directions to ensure that hearing materials (including medical reports) are available to participants sufficiently in advance of hearings to facilitate proper consideration. ▪ The Tribunal will provide a range of convenient participation options (including telephone, videoconference, or in-person). ▪ The Tribunal will ensure participants know their participation at hearings is valuable and contributes to the outcome. ▪ The Tribunal will make information about the Tribunal's processes publicly available and will refer participants to these sources of information.
We will improve how we work and maximise our use of technology.	▪ The Tribunal will implement a case management system which facilitates, monitors, and reports on compliance with statutory functions and statutory timeframes and supports the transition to electronic delivery of hearing materials. ▪ The Tribunal will enhance its website to provide greater access to information and Tribunal forms. ▪ The Tribunal will conduct video/tele-conference hearings as required to meet urgent timeframes and maximise Tribunal efficiency. ▪ The Tribunal will transition to an electronic records management system to comply with its statutory record-keeping obligations.
We will build our capacity and make best use of our resources.	▪ The Tribunal will recruit and reappoint members solely on merit through an open recruitment process. ▪ The President will develop and implement a mandatory continuing professional development program for members. ▪ The Tribunal will appoint members on a full time, part time, or sessional basis as required to ensure availability and to maximise Tribunal efficiency. ▪ Tribunal members will demonstrate mastery of the core competencies identified in the COAT Tribunal Competency Framework, conduct themselves in accordance with relevant Codes of Conduct, and demonstrate commitment to ongoing development. ▪ The Tribunal Registry will utilise best practice in case flow management. ▪ The Tribunal Registry will articulate its administrative processes in a manual which will be publicly available. ▪ The President will commence implementation of the COAT Tribunal Excellence Framework. ▪ The President will maintain links and exchange ideas with Mental Health Tribunals and other Tribunals throughout Australia. ▪ All members and staff will demonstrate a commitment to best practice and maximising Tribunal efficiency.

Appendix Three: Relevant Principles

Mental Health Act s 10 - Objects of the *Mental Health Act 2014*

(1) The objects of this Act are as follows —

(a) to ensure people who have a mental illness are provided the best possible treatment and care —

(i) with the least possible restriction of their freedom; and

(ii) with the least possible interference with their rights; and

(iii) with respect for their dignity;

(b) to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

(c) to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options that are available for their treatment and care;

(d) to help minimise the effect of mental illness on family life;

(e) to ensure the protection of people who have or may have a mental illness;

(f) to ensure the protection of the community.

(2) A person or body performing a function under this Act must have regard to those objects.

Mental Health Act Schedule 1 - Charter of Mental Health Care Principles

Purpose

The Charter of Mental Health Care Principles is a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.

The Charter is intended to influence the interconnected factors that facilitate recovery from mental illness.

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

Principle 3: Person-centred approach

A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences, needs, preferences, aspirations, values, and skills, while delivering goal-oriented treatment, care, and support.

A mental health service must promote positive and encouraging recovery-focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

Principle 5: Choiceand self-determination

A mental health service must involve people in decision-making and encourage self-determination, cooperation and choice, including by recognising people's capacity to make their own decisions.

Principle 6: Diversity

A mental health service must recognise and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant

members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

Principle 8: Co-occurring needs

A mental health service must address physical, medical, and dental health needs of people experiencing mental illness and other co-occurring health issues, including physical and intellectual disability, and alcohol and other drug problems.

Principle 9: Factors influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Principle 10: Privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality.

Principle 11: Responsibilities and dependants

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependants.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects, and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance, and uphold their rights.

Principle 14: Involvement of other people

A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating, and improving their treatment, care and support.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.

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