

2013 2014 Annual Report

Mental Health Review Board
Psychosurgery Review Board



2013 / 2014 Annual Report

Mental Health Review Board





*Mental Health
Review Board
of Victoria*

12 August 2014

The Honourable Mary Wooldridge MP
Minister for Mental Health
Department of Health
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

Dear Minister

I am pleased to present the Mental Health Review Board's final annual report of its operations for the period 1 July 2013 to 30 June 2014.

Yours sincerely

A handwritten signature in black ink that reads "Matthew Carroll".

Matthew Carroll
President

Contents

Overview	4	Priority 2:	13
Who we are	4	<i>Maintain and develop the knowledge, culture and capacity of the Board</i>	
Purpose	4	Board and Tribunal membership	13
Vision	4	Professional development	13
Mission	4	Development of resources for members	14
The Board's obligations under the Charter of Human Rights and Responsibilities	4	Staff recruitment and development	14
Membership changes during 2013/14	4	Priority 3:	15
Report on operations for 2013/14	4	<i>Integrate and transition the operations of the Board to the Mental Health Tribunal</i>	
Organisational Structure	5	Consultation with key stakeholders	15
President's Message	6	Key Initiatives	15
Priority 1:	7	Accommodation	15
<i>Implement our statutory functions in accordance with our charter obligations</i>		Case listing and case management	15
Functions	7	Design of the Tribunal hearing schedule based on caseload modelling and stakeholder input	16
Reviews and Appeals	7	Video-conferencing network	16
Jurisdiction	7	Rules, Practice Notes and information products	16
Practices and Procedures	8	Financial Summary	17
Divisions of the Board	8	Appendix A	18
Location of Hearings	8	Membership List	
Hearings by Video-conferencing	8	Appendix B	19
Scheduling Hearings	8	Educational Activities 2013/14	
Notices of Hearings	8	Appendix C	20
Hearing Procedures	8	Compliance Reports	
Interpreters	8		
Advocates and Representation	8		
Decision Making and Review	8		
Statements of Reasons	8		
Applications for review to the Victorian Civil and Administrative Tribunal	9		
Educational Activities	9		
Key 2013/14 statistics at a glance	9		
Hearings and Cases	9		
Hearings	9		
Cases	10		
Primary diagnoses of patients reviewed by the Board	12		
Applications for review by VCAT	12		

Terminology in this Annual Report

There is continuing debate about the most desirable or acceptable terminology to describe people who have a mental illness and who receive involuntary treatment. Diverse views on terminology are acknowledged. However, for the purpose of this report, the terms 'patient', 'involuntary patient' and 'security patient' are used when referring to the individuals whose reviews and appeals are heard by the Board. This accords with the terminology used in the provisions of the *Mental Health Act 1986*, which defines the functions of the Board.

Overview

Who we are

The Mental Health Review Board (Board) is an independent statutory tribunal established under the *Victorian Mental Health Act 1986* (the Act). The Act sets down the criteria that must be satisfied for a person to receive involuntary treatment for a mental illness, in either a hospital or the community. The primary function of the Board is to decide whether people being treated as involuntary patients meet those criteria in order for involuntary treatment to continue. If the Board does not believe those criteria are met, it discharges a person from their involuntary status, enabling that person to make their own decisions regarding treatment.

Purpose

The Board's purpose is to monitor the imposition of civil commitment for reasons of mental illness, by providing an expert and independent tribunal that conducts reviews of decisions made by authorised psychiatrists to treat people as involuntary or security patients.

Vision

The Board's vision is to:

- be respected and recognised as an expert body that operates sensitively to the needs of its users, and which fairly balances the rights of people with a mental illness, their families and carers, and the community as a whole;
- remain an efficient, effective and independent organisation empowered to protect the rights of people with a mental illness.

Mission

The Board's mission is to provide an accessible mechanism of independent review that is impartial, skilled, fair, informal and expeditious, and which ensures the protection of rights according to law.

The Board's obligations under the Charter of Human Rights and Responsibilities

The Board has always operated from a rights-based perspective. As a public authority under the *Charter of Human Rights and Responsibilities* (the Charter), it must adhere to a number of human rights obligations. The Charter requires the Board to give proper consideration to all relevant human rights when making decisions; it must also act compatibly with human rights. This requires the Board to be attuned to the potential impact on human rights of all our activities. In addition, when undertaking the specific task of interpreting the Mental Health Act, the Board must do so in a way that is compatible with human rights, provided that to do so is consistent with the purpose of the Act.

Membership changes during 2013/14

As part of the Tribunal establishment project, the Board once again worked in partnership with the Royal Australian and New Zealand College of Psychiatrists to recruit new psychiatrist members. The support of the College is always invaluable when the Board is looking to attract new psychiatrist members. This year was no exception. On 11 March 2014 the Governor in Council appointed 10 new psychiatrist members. The Board is delighted to welcome:

Dr Joe Black
Dr Tom Callaly
Associate Professor John Fielding
Dr Yvonne Greenberg
Associate Professor Anne Hassett
Dr Grant Lester
Dr Samantha Loi
Dr Guntavt Patel
Dr Joanna Selman
Dr Jennifer Torr

The Board also farewelled a small number of members. Two psychiatrist members, Dr Angelo Rodrigo and Dr Michael Jonas, retired from hearings effective 30 June. The Board thanks both Dr Rodrigo and Dr Jonas for their valuable contribution to the work of the Board.

Ms Lynne Coulson Barr retired as a community member to take up her appointment as Victoria's first Mental Health Complaints Commissioner under the *Mental Health Act 2014*. The Board congratulates Ms Coulson Barr and looks forward to an ongoing working relationship with her as she establishes this critical new role.

This year Mr Graeme Bailey, a legal member of the Board, reached the milestone of 25 years continuous service. Mr Bailey is a solicitor in Wangaratta and his contribution to the work of the Board over this time has included playing a critical role in the Board's capacity to undertake hearings at a number of regional venues. The Board thanks Mr Bailey for his dedicated service to the Board, and through it, to the community.

Report on operations for 2013/14

Previously the Board's business plan identified four priorities, namely:

Priority 1: implement our statutory functions in accordance with the Charter.

Priority 2: maintain and develop the knowledge, culture and capacity of the Board.

Priority 3: pursue ongoing improvements to the way in which we work.

Priority 4: commence the establishment of the proposed Mental Health Tribunal.

During 2013/14, there was a significant shift from establishing the Tribunal to integrating and transitioning the operations of the Board to the Mental Health Tribunal. This report summarises the Board's key achievements against the following three priorities:

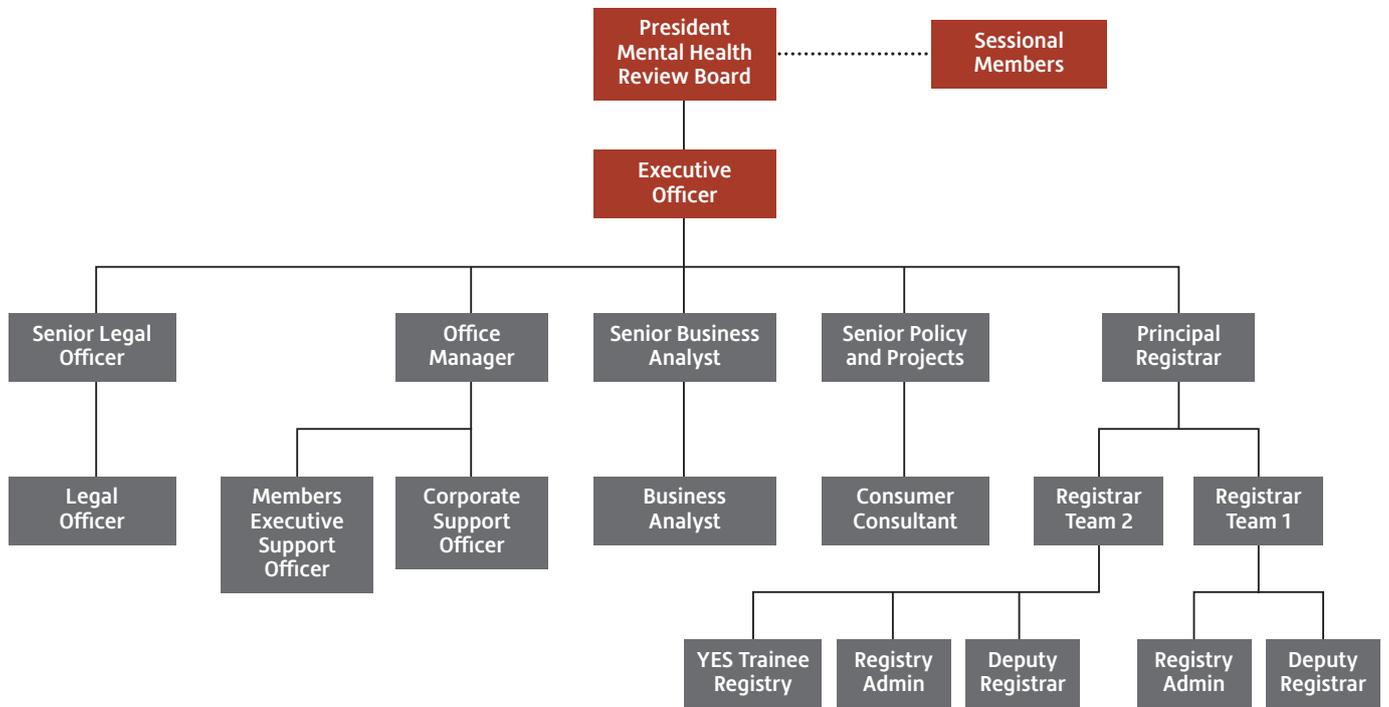
Priority 1: implement our statutory functions in accordance with our Charter obligations.

Priority 2: maintain and develop the knowledge, culture and capacity of the Board.

Priority 3: integrate and transition the operations of the Board to the Mental Health Tribunal.

Organisational Structure

Organisational Chart at June 2014



President's Message

Welcome to the final annual report of the Mental Health Review Board. On 1 July 2014, with the commencement of the *Mental Health Act 2014*, the Board will cease. In its place the Mental Health Tribunal will be established. While this is a cause for reflection and some nostalgia, it is primarily a time of enthusiasm and invigoration – these reforms are long anticipated.

The Board's final year of operation has been extraordinarily busy. Alongside the need to maintain business as usual under the *Mental Health Act 1986*, we have been building a new entity from the ground up. Of course, the operation of the Board and the accumulated knowledge and expertise of its members and staff provide a very firm foundation for the Tribunal, but the Tribunal is not the Board with a different name; it is something very different. Many of the Tribunal's functions and responsibilities bear similarities to those of the Board, but as a primary decision maker regarding the making of compulsory treatment orders rather than a review body, the Tribunal will occupy a very different place in the legal framework governing compulsory treatment for people experiencing severe mental illness.

Over time, the role of the Mental Health Review Board had become disconnected from the provision of treatment, and hearings could be perceived as a distraction from patient care. The new Act refutes this misconception. It recognises and reinforces that when it is thought necessary to treat a person on a compulsory basis, an obligation that follows is that of articulating the reasons for this; presenting the evidence that supports such a view; and engaging in a comprehensive discussion about these matters with the patient, the people who support them and the Tribunal. Understood in this way Tribunal hearings are clearly about treatment and care – they are about the treatment and care of the person who is the subject of a particular hearing.

This in turn creates a significant responsibility for the Tribunal. It must perform its functions in such a way as to preserve and foster relationships between the people participating in hearings; and it should also strive to make the time spent in hearings as relevant and constructive as possible. In this context I am particularly proud of the work undertaken by the Board to develop the *Guide to Solution-Focused Hearings in the Mental Health Tribunal*. This framework will guide the practice and approach of the Tribunal, and in particular sets down a commitment to engage with hearing participants as the best source of options for durable and effective hearing outcomes. This guide (which will be available on the Tribunal's website www.mht.vic.gov.au) should also be understood as a starting point. Like all other entities that will operate under the new Act, the work of the Board over the past 12 months is only the first phase in the process of culture change that is needed to embed the principles of the new legislation.

This year – perhaps more than in any other – I must acknowledge the hard work of an exceptionally skilled and committed group of staff. There have been times over the past year when workloads have been extremely heavy and timelines exceedingly tight. In addition, when implementing such a complex change agenda, things don't always go as planned. Across the entire organisation staff have responded to these challenges professionally – and with good humour – and whenever unforeseen problems emerged, they instantly started planning alternative strategies.

I also want to thank the Board's members for their hard work and commitment during this extraordinary year. Each week members are responsible for conducting many hearings and on occasion, daily hearing lists can be extremely long. Despite this members always focus upon providing each individual with a fair, respectful and thorough hearing. Alongside this members have enthusiastically engaged with the reform agenda, and particularly in the later part of the year familiarised themselves with and absorbed an extremely large amount of information relating to the new Act

and the proposed operation of the Tribunal. Members have also contributed invaluable ideas and suggestions based not only on their experience as Board members, but drawing on their breadth of professional and personal experience elsewhere.

The work undertaken to establish the Mental Health Tribunal did not occur in isolation, and in fact could not have succeeded without constructive and effective collaboration with the Department of Health and Victoria's mental health services. I want to thank the Department for its support and full inclusion of the Board in the Mental Health Act Implementation Project. I also want to acknowledge the work of the Mental Health Act Implementation Project Managers based in mental health services who allocated a great deal of their time and effort to working with the Board on the implementation of processes to facilitate the work of the Tribunal under the new Act. Finally I want to thank the members of the Board's Stakeholder Advisory Group who provided invaluable input on a range of initiatives, including providing advice on how the Tribunal can foster more effective relationships with its stakeholders in the future.

We are in a unique and indeed privileged position to be charged with the responsibility of establishing the Mental Health Tribunal and playing a key role, alongside many others, in promoting these fundamental reforms to the way in which our community approaches compulsory treatment for severe mental illness. Already we have ideas about the things we may do, and in particular the things we may do differently, but the Tribunal is also committed to implementing an agenda that is based on direct input from stakeholders, and establishing the mechanisms that will enable this input will be an initial priority. I look forward to reporting on our progress in future annual reports of the Mental Health Tribunal.

Matthew Carroll
President

Priority 1

Implement our statutory functions in accordance with our charter obligations

The Board's core business is to perform its functions as set out in the Act, in accordance with the Board's obligations as a public authority under the Charter of Human Rights and Responsibilities.

Functions

The functions of the Board set out in s22(1) of the Act are to:

- (a) hear appeals by or on behalf of involuntary patients and security patients;
- (b) review periodically the orders made for involuntary patients and security patients and their treatment plans;
- (c) hear appeals against the refusal of the chief psychiatrist to grant special leave to security patients;
- (ca) hear appeals against the transfer of involuntary patients and security patients;
- (d) review orders for the transfer of involuntary patients to interstate mental health facilities; and
- (g) such other functions as are specified in the Act.

Reviews and Appeals

Reviews are automatically conducted by the Board as a duty imposed upon it by the Act. The Board is required by s30 to review the continued treatment of all involuntary and security patients within eight weeks of the making of the relevant order, and thereafter at intervals not exceeding 12 months. The Board also reviews decisions to extend community treatment orders (CTOs).

By contrast, appeals are initiated by, or on behalf of, patients. Pursuant to s29, patients may lodge appeals with the Board at any time against their continued treatment as involuntary or security patients, and the Board is required to commence the hearing of an appeal without delay. A friend, relative or community visitor may lodge an appeal with the Board on behalf of a patient.

Jurisdiction

The Board may determine the following types of cases:

- The ongoing status of individuals who are hospital inpatients on involuntary treatment orders (ITO), or living in the community and receiving treatment under a CTO. Generally, the Board's decision will be to either uphold the ITO or CTO, or alternatively, discharge the person from the order, meaning they become a voluntary patient and make their own treatment decisions. In addition, however, when reviewing an ITO the Board can order that a patient be placed on a CTO within a reasonable period, and, when reviewing a CTO, the Board has discretion to vary or revoke the order.
- The Board reviews two categories of security patients – those under s16 of the Mental Health Act, and those under s93A of the *Sentencing Act 1991*. If the Board is not satisfied that the specific criteria applicable to security patients are met, it may discharge those patients, in which case they return to prison.
- Reviews of the involuntary status of individuals on hospital orders, restricted ITOs and restricted CTOs – all of which involve the intersection of various provisions of the Mental Health Act and Sentencing Act.
- Involuntary and security patients may appeal against a decision to transfer them from one approved mental health service to another within Victoria. The Board must also review decisions to transfer patients to an interstate mental health facility.
- Under s42 of the Act, an involuntary patient who has been absent without leave, or who has been on leave of absence for a continuous period of twelve months, is automatically discharged as an involuntary patient. However, the Chief Psychiatrist or the authorised psychiatrist may apply to the Board for an order that the involuntary patient not be automatically discharged.

- Security patients can lodge appeals against the refusal of the Chief Psychiatrist to grant special leave of absence. Special leave cannot exceed 24 hours and must be for a specific purpose.
- Review of the continued detention of a patient under s12A-12D of the Act. These provisions cover a person who, despite not meeting the usual criteria to be an involuntary patient, appears to have a mental disorder, and who, if not detained and treated, would cause serious physical harm to themselves. (No cases have come to the Board for determination under these provisions since they commenced operation in July 1996.)

Practices and Procedures

Divisions of the Board

The Act requires the Board to sit as a division of three members, except when conducting a periodic (annual) review, a review of the extension of a community treatment order, or a review of an interstate transfer. In these cases, the Board can be constituted by either a division of three members or a single member division. Each division of three is made up of a legal member, a psychiatrist member and a community member; whereas a single member division may be constituted by a member from any category. In the case of a three-member division, the legal member must be the chairperson.

Location of Hearings

The Board attends 52 venues regularly – generally fortnightly, although some venues have weekly hearings. Some divisions visit more than one mental health service on the same day as part of a circuit.

Hearings by Video-conferencing

The use of video-conferencing enables the Board to provide a timely service to patients located furthest from Melbourne. Throughout the year, hearings for Mildura and Warrnambool were regularly conducted by video-conference from the Board's office. The Board also accessed remote clinics from other regional centres such as Wangaratta, Traralgon, Ballarat and Shepparton.

Scheduling Hearings

The responsibility for scheduling hearings rests with the Board's Registry, who liaise with the medical records staff at each of the mental health services to coordinate and confirm the hearings list.

On being made an involuntary patient by an approved mental health service, the patient's details are entered into the statewide mental health database by the treating mental health service. The Board draws upon this information to schedule initial reviews, CTO extension reviews, as well as periodic (annual) reviews if a person remains an involuntary patient for an extended period.

A hearing may also come about by an appeal being lodged under s29. In most instances, appeal hearings are scheduled on the next sitting-day when a division of the Board is due to visit the service where the person is receiving treatment.

Notices of Hearings

A notice of a hearing is generally provided to the patient and the authorised psychiatrist. Notice of a hearing must be given at least seven days before the day of the hearing. The Board may exercise its discretion to reduce this notice-period.

Hearing Procedures

The Act provides a framework for Board procedures, but also allows considerable discretion in determining the manner in which hearings are conducted. Hearings aim to be informal, inclusive and non-adversarial. Given the nature of its work, the Board 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.

Hearings are usually conducted in a meeting or seminar room of the mental health service where the patient is being treated. Generally, those present at a hearing, other than the Board members, are the patient and the treating doctor who attends as the representative of the authorised psychiatrist. When a person is on a CTO their case manager will often attend as well – something the Board strongly encourages. In some cases, friends and relatives of the patient also attend.

Interpreters

The Board provides interpreters whenever requested by a patient or a mental health service. Even though a person may have basic English skills, this may not be adequate in the situation of a hearing involving complex legal and clinical issues. Availability of a competent professional interpreter is important to ensure that patients can fully understand and participate in the hearing process. Figures on the use of interpreting services are shown in the "Statistics" section of this report.

Advocates and Representation

Some patients are unable to present their cases as well as they might wish because of their illness, or they may be reluctant to speak openly at a Board hearing. The presence of an advocate provides support and ensures that the patient's rights are appropriately protected. Legal representation is not an automatic right in Victoria and it is the responsibility of patients to arrange their own representation. Victoria Legal Aid regularly provide free legal representation at hearings. Figures relating to legal representation are shown in the "Statistics" section of this report.

Decision Making and Review

Statements of Reasons

The Board's decision in a particular review or appeal is delivered orally at the conclusion of the hearing and is also reflected in a written order. In some matters, the Board later provides a written statement of reasons. This can be at the request of a party to proceedings, as a result of an application for review to the Victorian Civil and Administrative Tribunal (VCAT), or on the Board's own initiative.

When a party to a hearing requests a statement of reasons, the Act requires the request to be in writing, and it must be made within 28 days of the determination of the Board. The Act also requires the Board to provide the statement of reasons within 14 days of receiving the request. When the statement is required as a result of an application for review to VCAT, the *Victorian Civil and Administrative Tribunal Act 1998* (the VCAT Act) requires that it be provided within 28 days of the request.

Any statement that is produced is distributed to the patient, their legal representative (if any), and the authorised psychiatrist of the relevant mental health service. In order to protect the privacy of patients and witnesses, statements of reasons refer to all such persons by their initials only.

During the current year, the Board received 89 requests for a statement of reasons. Members voluntarily prepared an additional five statements of reasons.

Applications for review to the Victorian Civil and Administrative Tribunal

Any party to Board proceedings may apply to VCAT for a review of a Board determination. VCAT has the power to affirm, vary, or set aside the Board's decision, and either make a substitute decision or remit the matter to the Board for reconsideration. In practice, VCAT conducts a *de novo* hearing, at which it rehears the matter, taking into account evidence about whether the involuntary patient meets the statutory criteria at the time of the VCAT hearing.

Formally, the Board 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 Board submits to the jurisdiction of VCAT and does not take an active role in the proceedings. The Board files all the required materials with VCAT, which then conducts a hearing involving the person who made the application, and the mental health service that is responsible for their treatment. Of course, the Board is always available to respond to questions VCAT may have regarding the relevant proceedings and determination, and will attend a hearing if requested to do so by VCAT in a particular matter.

Further details relating to reviews by VCAT are provided in the "Statistics" section of this report.

Educational Activities

Each year the Board pursues a range of activities to explain its role and the framework for involuntary treatment established by the Act. This includes general information presentations delivered by the President, as well as initiatives to promote a deeper understanding of the requirements of the Act. Educational activities delivered by the Board during the year are listed in appendix B.

Key 2013/14 statistics at a glance

13,045	Hearings listed
5,515	Hearings conducted
2,768	Patients attended their hearing
701	Patients with legal representation
110	Interpreters at hearing
333	Patients discharged
89	Statements of Reasons requested
20	Applications to VCAT

A new case management system was implemented in November 2013. In transitioning data across to the new system, vulnerabilities were identified. The statistical reports that have been produced have been supplemented with a variety of manual systems. While manual systems are associated with a degree of risk in relation to accuracy, figures have been reviewed and checked to minimise this risk and possible errors.

Hearings and Cases

The Board gathers and reports statistics on the basis of both hearings and cases. A hearing is the 'event' where the Board meets with the patient, their treating team and, where involved, their carer and advocate. Each hearing may consist of more than one case, depending on the circumstances of the patient. For example, if a patient is listed for an initial review and she or he also files an appeal, we will list the two cases to be heard concurrently in the one *hearing*.

Hearings

Table 1: Total hearings conducted by the Board

Hearings	2013/14		% variation on 2012/13	2012/13		2011/12	
	Number	%		Number	%	Number	%
Listed	13 045	100	-11%	14 623	100	15 238	100
Not required #1	3 117	23.9	+8%	2 891	19.7	2 667	17.5
Adjourned	1 821	14.0	-21%	2 305	15.7	2 107	13.8
Rescheduled #2	2 176	16.7	-27%	2 963	20.2	3 839	25.2
Conducted	5 515	42.3	-8%	6 011	41.1	5 964	39.1

#1 includes patient discharged from involuntary status prior to the hearing; appeal withdrawn.

#2 whereas an adjournment is a decision made by the Board at hearing, a reschedule is where a new date of hearing is set by the Registry. This will only be done if the rescheduled date is within statutory timelines.

Table 2: Hearings conducted by the Board – by Division

	2013/14	2012/13	2011/12
Number of divisions	1 269	1 272	1 159
Average number of hearings listed per division	10	12	13
Average number of hearings conducted per division	4	5	5
Average Number of hearings adjourned per division	1	2	2

After years of relatively consistent hearing-related statistics, our figures for 2013/14 look quite different to previous years. In particular:

- we listed approximately 1,600 fewer matters;
- adjournments decreased by over 20%;
- rescheduled matters decreased by over 25%.

The statistics reflect that since January 2014 in particular, services and the Board have been working to incrementally introduce practices and procedures that would position services and the Board to comply with the new Act when it commences on 1 July. One very significant change is that the new Act will greatly reduce the ability to reschedule or adjourn matters, accordingly services and the Board placed a particular emphasis on reducing reschedules and adjournments during 2013/14. The significant fall in adjournments and reschedules is a product of a combination of factors, including:

- a decrease in service-initiated requests for adjournments;
- fewer adjournments were granted by divisions of the Board; and
- fewer service-initiated requests for reschedules, and more scrutiny given before the Registry would reschedule a matter.

Our statistics also indicate that fewer patients were involuntary at the time when the Board would ordinarily commence the process of listing a hearing (about 4-5 weeks from a person being made an involuntary patient, or having their CTO extended). As a result, overall hearings conducted by the Board fell by 8%. This trend emerged largely in the second half of the year and it is reasonable to hypothesise that, at least in part, it was a consequence of treating teams, when making decisions under the *Mental Health Act 1986*, taking into consideration the higher threshold for compulsory treatment under the new Act from 1 July.

Table 3: Profile of hearings

	2013/14		2012/13		2011/12	
	Number	%	Number	%	Number	%
Patient Attended Hearing	2 768	50.0	3 009	50.0	2 826	47.4
Patient Did Not Attend Hearing	2 769	50.0	2 400	40.0	3 138	52.6
Legal Representation [‡]	701	12.7	673	11.2	622	10.4
Family attended	409	7.4	517	8.6	475	7.7
Friends attended	67	1.2	53	<1	81	1.4
Hearing conducted by video-conference	105	1.9	149	2.5	158	2.6
Telephone attendance involved	35	<1	65	1.1	56	<1
Interpreter	110	2.0	155	2.5	184	3.1
Non-disclosure applications	107	1.9	146	2.4	133	2.2
Statements of Reasons	89	1.6	162	2.7	155	2.6

[‡] The following table provides a breakdown of the organisations which provide legal representation.

	2013/14		2012/13		2011/12	
	Number	%	Number	%	Number	%
Victoria Legal Aid	652	11.8	498 *	8.3	455	7.6
Mental Health Legal Centre	21	<1	140	2.3	142	2.4
Private Lawyer	19	<1	25	<1	16	<1
Other Lawyer	9	<1	10	<1	9	<1

* Due to a reporting error, this figure has been corrected from 546 which was reported last year.

Cases

Table 4: Total cases listed and their manner of finalisation

	2013/14		2012/13		2011/12	
	Number	%	Number	%	Number	%
Listed	15 446	100	17 937	100	18 646	100
Discharged prior to hearing	3 241	21.0	3 269	18.2	3 133	16.8
Appeal withdrawn	102	<1	107	<1	94	<1
Not Required ^{#1}	205	1.3	187	1.0	260	1.4
Adjourned	2 207	14.3	2 875	16.0	2 627	14.1
Rescheduled ^{#2}	2 497	16.2	3 440	19.2	4 541	24.3
No jurisdiction ^{#3}	38	<1	16	<1	10	<1
Cases determined	7 156	46.3	8 043	44.8	7 980	42.8

^{#1} e.g. cases where the purpose of listing the hearing is no longer relevant. For example, a division of the Board may direct that an early review be conducted if a person is still an involuntary in-patient in three months' time. If by the time of the early review hearing the patient has been discharged or placed on a CTO, the review will no longer be required.

^{#2} whereas an adjournment is a decision made by the Board at hearing, a reschedule is where a new date of hearing is set by the registry. This will only be done when the new date is within statutory timelines.

^{#3} e.g. the Board found that the procedures for making a person involuntary or continuing their involuntary status had not been complied with, and the error was too significant to be corrected under s121 of the Act.

Table 5: Board determinations by case type

	2013/14		2012/13		2011/12	
	Confirmed	Discharged	Confirmed	Discharged	Confirmed	Discharged
Inpatient						
Initial review	914	85	1 098	72	1 136	77
Annual review	268	12	194	10	203	8
Appeal	579	52	619	39	604	30
Early review	65	6	47	3	46	1
Application by Authorised Psychiatrist for Board to reconsider a direction to place a patient on a CTO	4	0	4	1	3	0
Community (CTO)						
Initial review	1 075	96	1 181	138	1 176	121
Annual review	1 676	42	1 985	71	1 986	70
Appeal	517	39	499	50	464	54
Extension review	1 341	42	1 714	56	1 661	48
Early review	118	22	97	29	86	18
Other (security, RITO, RCTO)						
Initial review	48	1	70	1	74	1
Annual review	7	0	3	0	7	0
Appeal	4	1	9	1	11	0
Extension review	1	0	0	0	0	0
Early review	0	0	1	0	0	0
Total	6 617	398	7 521	471	7 457	428

Case Study 1

P was diagnosed with paranoid schizophrenia about 10 years ago. At that time, he was experiencing auditory hallucinations, paranoid beliefs and had acted aggressively. P had been treated on a community treatment order for several years with antipsychotic and mood stabilising medication.

At the hearing, the Board heard evidence that P had recently not exhibited any symptoms of his mental illness. The Board discussed whether this meant P did not satisfy the second criterion for involuntary treatment – did P’s mental illness require immediate treatment and could that treatment be obtained by P being subject to a community treatment order?

The Board came to the conclusion that a key reason for P not having active psychotic symptoms was because he had been receiving ongoing and effective treatment, including antipsychotic and mood stabilising medications. The Board therefore found that this criterion was satisfied.

Under the new Act, the Tribunal must determine whether immediate treatment will be provided to the patient if they are subject to a Treatment Order.

Case Study 2

The first issue that the Board needed to determine at a hearing was whether the patient appears to be mentally ill. P was diagnosed with schizophrenia and was being treated subject to a community treatment order. The doctor at the hearing had assessed P. At the time of assessment, P did not appear symptomatic. At the hearing, the treating team did not provide conclusive evidence of P’s other reported symptoms. A reading of P’s clinical file did not reveal any other evidence supporting the reported symptoms.

The Board noted the fact that P had had previous hospital admissions for his mental illness. However, the Board found the previous admissions were not indicative that P had a mental illness at the time of hearing.

Based on the evidence presented to the Board, which did not sufficiently establish that P suffered a mental illness, the Board found this criterion was not satisfied, and so discharged P from his community treatment order.

Under the new Act, the Tribunal still needs to consider whether a patient has mental illness. Mental illness is defined as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. It will no longer be sufficient for a person to appear to be mentally ill, it must be established they have mental illness.

Primary diagnoses of patients reviewed by the Board

In preparing their reports for the Board, treating doctors note the primary diagnosis of the patient. This list of diagnoses is represented as an indicative percentage of the primary diagnosis of patients who have Board hearings.

	2013/14 %
Schizophrenia	50.6
Schizoaffective disorder	18.1
Bipolar affective disorder	8.7
Paranoid schizophrenia	6.4
Delusional disorder	1.8
Depression	1.0
Chronic paranoid schizophrenia	<1
Dementia	<1
Drug induced psychosis	<1
Eating disorders	<1
Other organic disorders	<1
Paranoid psychosis	<1
Other	11.4

Discharge determinations – criteria under which patients were discharged

In 2013/14, the Board discharged 333 patients (in 2012/13 it discharged 372; and in 2011/12 it discharged 348). The most common ground of discharge, in descending order, were as follows:

- Adequate treatment is able to be provided in a less restrictive manner [i.e. s8(1)(e) did not apply]
- Person is able to consent and is consenting to necessary treatment [i.e. s8(1)(d) did not apply]
- Involuntary treatment is not necessary for either the person's health or safety or to protect members of the public [i.e. s8(1)(c) did not apply]
- Person's mental illness did not require immediate treatment [i.e. s8(1)(b) did not apply]
- Person did not appear to be mentally ill [i.e. s8(1)(a) did not apply]

Due to issues extracting this data from the case management system, this is an indicative ranking based on 7 months of the reporting year.

Applications for review by VCAT

Table 6: Number of applications and their status in 2013/14

	2013/14	2012/13	2011/12
Applications carried over from previous financial year	1	7	3
Applications made during financial year	20	16	22
Applications withdrawn during financial year	6	3	6
Applications struck out or dismissed during financial year	3	7	3
Applications proceeded to full hearing and determination during financial year	8	12	9
Applications pending at 30 June 2014	4	1	7

Table 7: Outcome of applications determined by VCAT during 2013/14

	2013/14	2012/13	2011/12
Decision affirmed	8	11	9
Decision set aside	0	1	0

Case Study 3

At the hearing, P told the Board and his treating team that he experienced side-effects from his depot medication. He wanted to stop the depot and receive oral medication.

The treating team had planned to transition P to oral medication in the next few months if P remained free from drugs and alcohol. P had undergone recent drugs tests that indicated he was drug free. Additionally, he was participating in drug and alcohol education programs.

The Board did not have any power under the Act to decide what treatment patients should receive. However, the Board decided that the authorised psychiatrist had not taken P's wishes into account in preparing the treatment plan, which was not in accordance with section 19A of the Act. The Board therefore ordered the authorised psychiatrist to revise the treatment plan to take into account P's wishes to be treated with oral medication rather than depot.

Under the new Act, the Tribunal will no longer review treatment plans. However, the Tribunal must be provided with a very clear picture regarding the treatment that is proposed for an individual patient. This will inform the Tribunal's consideration of the treatment criteria, and if a Treatment Order is made, will inform the Tribunal's determination regarding the category and duration of the Order. Like the Board, the Tribunal will not be making decisions regarding specific treatments, although it will be required to authorise the use of ECT in the treatment of adult patients who do not have capacity, and in the treatment of any person under 18 years of age.

Priority 2

Maintain and develop the knowledge, culture and capacity of the Board

The Board must have sufficient members and staff to effectively perform its functions under the current Act, and to effectively prepare for future operation as the Mental Health Tribunal. Training and development is a key component of this strategy, but equally important is a framework of mutual understanding – with staff, members, stakeholders and the Department.

Board and Tribunal membership

The transitional provisions in the *Mental Health Act 2014* provide that all members of the Mental Health Review Board will, from 1 July 2014, become members of the Mental Health Tribunal. However, the Tribunal will have a different structure to the Board and as such a number of appointments needed to be finalised during the reporting year in order for them to take effect from 1 July. Accordingly the Board worked with the Department of Health on the recruitment and appointment of a Deputy President, two full-time senior legal members, eight part-time members, and the first group of registered medical practitioner members.

Deputy President:

Ms Dominique Saunders

Senior Legal Members:

Ms Troy Barty

Ms Emma Montgomery

Part-Time Members:

Mr Duncan Cameron (Community member)

Dr Sue Carey (Psychiatrist member)

Mr Ashley Dickinson (Community member)

Mr Brook Hely (Legal member)

Ms Kim Magnussen (Community member)

Dr Nick Owens (Psychiatrist member)

Dr Diane Sisely (Community member)

Ms Helen Walters (Community member)

Registered Medical Practitioner Members:

Dr Adeola Akadiri

Dr Patricia Buckeridge

Dr Louise Buckle

Dr Naomi Hayman

Dr Alan Hodgson

Dr David Marsh

Dr Helen McKenzie

Dr Sharon Monagle

Dr Deborah Owies

Dr Stathis Papaioannou

Professional development

During 2013/14, the Board's professional development program focused on issues arising from the proposed reforms and, following the passage of the Bill through parliament, the provisions of the *Mental Health Act 2014*. The Board conducted three members' forums that focused on the following issues:

- the provision of evidence for Tribunal hearings – in particular the design of templates for hearing reports;
- managing the transition from the current Act to the new Act including case management strategies, and developing improved working arrangements between the Tribunal and mental health services;
- briefing on research findings on the factors underlying the revocation of community treatment orders;
- electroconvulsive therapy;
- recovery oriented practice and its implications for Tribunal hearings.

The Board also provided a comprehensive induction program for all new appointees, including seminars, hearing observations and mentoring. In June, a full-day training event was held for members on the provisions of the new Act. The same program was delivered twice to maximise the opportunity for members to participate.

Case Study 4

P was on a community treatment order, which included a residential clause that she live at a supported residential service ("SRS") and receive treatment from the local mobile support team. P needed supervision in taking her medication as she had a poor understanding of her illness and did not want to take any medication. She had also been non-adherent with her medication in the past.

P did not want to live at the SRS because it was far from her family and she did not feel safe there. She wanted to manage her medication by herself.

The Board decided it should not use its power under section 36C of the Act to vary the residential clause in P's community treatment order. P had undergone an occupational therapy assessment that concluded that P would find the management of her self-care difficult. She also needed further education and rehabilitation before she could live independently.

The new Act does not contain a provision for residential clauses in community treatment orders. The Tribunal may only make a person subject to an Inpatient Treatment Order if the Tribunal is satisfied that the patient cannot be treated within the community.

Development of resources for members

Given members will be conducting and finalising hearings under the new Act from 1 July, a particular priority has been the development of a comprehensive suite of resources to assist members discharge their responsibilities. These resources were developed with the invaluable input of the Members' Advisory Committee. They include the following:

- 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 natural justice;
- a *Guide to Solution-Focused Hearings in the Mental Health Tribunal* – this commences the process of reflecting on how Tribunal hearings can be conducted in such a way as to promote the principles of the new Act;
- a comprehensive *Hearings Manual* that guides members through every type of hearing or application that can arise under the new Act; and
- preliminary guidance materials on the interpretation and application of the *Mental Health Act 2014*.

Staff recruitment and development

Over the course of the year, positions that were initially MHRB roles, and MHT project-specific roles, were integrated and transitioned into the overall staffing structure of the Tribunal. This equipped the organisation to meet the dual challenge of maintaining a significant focus on finalising the project-related activities needed to ensure the commencement of the Tribunal on 1 July, while simultaneously maintaining the "business as usual" of the Board up to 30 June.

Staff worked across teams to pool the expertise and input required to finalise work to the highest standard possible. All staff had opportunities to contribute to finalising policies and procedures. This resulted in co-ownership of policies and procedures that cut across the organisation. This, in turn, informed our internal training objectives, including how staff in other units understood the relationship of their work to that of their colleagues.

Training for the new Act was achieved through weekly meetings, small group sessions, and fortnightly e-bulletins. Training was not only about the functions of the new Act that staff in individual units needed to know. For example, Registry staff were trained in provisions relating to statements of reasons, and VCAT appeals, even though these matters are generally managed by staff in the legal unit. Additionally, the Department of Health provided a comprehensive session on the broader Mental Health Act 2014 reforms to assist staff in understanding the place of the Tribunal within the broader reform agenda.

Finally, there has been a focus on developing staff knowledge and skills to provide comprehensive assistance to members. With an expected membership of close to 140 members at 1 July, staff have been trained to respond ably to member queries that cut across different units. This training and development will continue after the Tribunal commences.

Case Study 5

In deciding whether to confirm a patient's involuntary or community treatment order, the Board needed to decide whether involuntary treatment is necessary for the patient's health or safety or for the protection of members of the public. Any of the three considerations could satisfy this criterion.

P had previously been trialled on a lower dose of medication, which had resulted in a relapse in his mental illness. The Board found that because P did not want to continue treatment, the involuntary treatment order was necessary for his health – to prevent a deterioration in his mental condition.

The treating team reported that P had suicidal thoughts a few years ago, which P disputed. The Board found this evidence was not enough to prove that P needed involuntary treatment for his safety.

During the hearing, P acknowledged carrying weapons in response to his persecutory delusions. When P suffered a relapse, he developed paranoia about members of the community. The Board therefore found involuntary treatment was necessary for the protection of members of the public.

Under the new Act, the Tribunal must similarly consider the patient's health, their safety and the safety of others. The Tribunal will consider whether the patient needs immediate treatment to prevent serious deterioration to their mental or physical health or serious harm to the patient or serious harm to another person. The requirement of serious deterioration or serious harm reflects that the new Act is clearly intended to be used to respond to these issues, but at the same time, sets a higher threshold than the former Act.

Priority 3

Integrate and transition the operations of the Board to the Mental Health Tribunal

Our investment of resources needs to be focused on systems that will translate to the Mental Health Tribunal. We will phase out the distinct Tribunal project work and start to integrate Board and Tribunal operations, in readiness for Tribunal commencement on 1 July 2014. Consulting with key stakeholders as far as possible to build our systems, policies and procedures will assist in positioning the Tribunal as a flexible and responsive organisation.

Consultation with key stakeholders

Previously, the Board convened its Stakeholder Advisory Group on an ad-hoc basis to share information (particularly in the context of the review of the Act), and explore issues of common interest. This year, the Stakeholder Advisory Group met on three occasions. This was supplemented by consultation in relation to specific initiatives, most notably the development of new reporting templates for Tribunal hearings under the new Act, and for advice on how the Tribunal can in the future most effectively maintain an ongoing dialogue with stakeholders, particularly consumers and carers. The Board greatly appreciates the valuable contribution to this collaboration by the Victorian Mental Illness Awareness Council, Tandem (formerly the Victorian Mental Health Carers Network), Psychiatric Disability Services of Victoria (VICSERV) and Victoria Legal Aid during 2013/14.

This year also saw the development of effective and responsive lines of communication between the Board and mental health services. This is largely attributable to the Mental Health Act Implementation Project Managers working at services across the state on a range of initiatives to prepare for the new Act, and to their having placed considerable emphasis on preparing for the new framework governing Tribunal hearings. Ongoing liaison with the Project Managers has facilitated continuous input by services into the operating policies and systems being developed by the Tribunal, thereby enabling emerging issues to be resolved quickly and effectively. Communication via Project Managers was supplemented by the CEO of each Health Service nominating a representative to receive and disseminate information relating to the establishment of the Tribunal. The Board has never had such well established lines of communication with mental health services and these will be maintained and enhanced by the Tribunal.

Key Initiatives

Accommodation

Over the course of December-January, the Board moved into new accommodation. While the physical move involved only shifting to the other side of the floor where the Board was located, our new offices are a dramatic improvement. The space is considerably larger, and the floor-plan is designed to reflect and facilitate the operation of the Tribunal. In particular, the Tribunal's offices include two purpose-built video-conference hearing rooms that will play a critical role in enabling the Tribunal to operate more flexibly and responsively than has historically been the case with the Board.

Case listing and case management

A key aspect of the Board's transition to the Tribunal has been the establishment of a robust Registry. Every matter coming before the Tribunal will be listed in accordance with rigorous and consistent case listing procedures. In addition, particular matters will also be case managed – matters that require extra planning and co-ordination to ensure they are able to proceed as planned. Over the first 12 months of the Tribunal's operation, we will case manage a range of hearings including any matter that is adjourned, all applications for an ECT Order, and any matter identified as complex (e.g. where additional parties need to be involved). Supporting Registry staff and the case listing and case management procedures is the Tribunal's case management system. Some technical difficulties with the case management system are still being resolved. Consequently, supplementary or back-up processes will remain in place while this work is completed.

Case Study 6

At P's hearing, P advised the Board she accepted her mental illness and agreed to continue with medication. However, P wanted to change her depot medication to oral medication.

The service thought P would not continue medication if she was a voluntary patient. The service said they would try oral medication in the future but not yet. P had had a relapse in the past when she was not closely supervised, so she needed to be treated on a community treatment order. The service thought it was in P's best interests for her to remain on a community treatment order.

The Board considered that although P did not have a real understanding of the nature of her mental illness, she accepted she had a condition that required treatment. The Board noted that the Act did not allow involuntary treatment just because it was in a patient's best interests. The Act required the Board to decide whether P could receive adequate treatment for the mental illness in a manner less restrictive of her freedom of decision and action. The Board decided that P could receive adequate treatment as a voluntary patient. P had been compliant with her medication for a long time and her mental illness had been stable for some time.

Under the new Act, the test is slightly different – the Tribunal will consider whether there is no less restrictive means reasonably available to enable the patient to receive the immediate treatment.

Design of the Tribunal hearing schedule based on caseload modelling and stakeholder input

It had been known for some time that the Tribunal would need to conduct hearings at community clinics and inpatient units more frequently than the Board (which has largely worked on a 'once-a-fortnight' model for many years), but precisely how often had not been determined. The analysis informing the design of the Tribunal's hearing schedule needed to include working out how often and when the Tribunal should attend 52 separate venues across the state; whether that attendance should be in-person or by video-conference; and whether the one division would conduct hearings at multiple venues on one day.

In consultation with mental health services, the Board reviewed historical data and endeavoured to model patient flows under the new Act. The Board also invited each of the 52 venues, and Victoria Legal Aid, to confirm preferences and constraints with regard to the scheduling of hearing days. Based on this data, the Board re-designed its hearing schedule and circulated a draft for a final round of feedback. The result is the Hearing Calendar that will govern the work of the Tribunal for the July-December period, which will be reviewed almost immediately once we have 'hands-on' experience of the operation of the new Act.

Video-conferencing network

The Tribunal will favour conducting hearings in-person; however, it is not possible for the Tribunal to be at all the places it needs to, and as often as required, without the use of video-conference connections. The capacity to conduct video-conference hearings is also critical to the Tribunal being able to hear matters quickly and flexibly when needed. The Tribunal will commence operation with point-to-point high quality video connections to all venues where it conducts hearings.

In the months following commencement, an analysis will be undertaken of the feasibility of establishing further connections to the remote satellite clinics that are part of some of the regional and rural mental health services. This capability will be invaluable to the Tribunal's effective performance of its functions, and be in compliance with the strict timelines for hearings set down in the new Act.

Rules, Practice Notes and information products

The Tribunal will commence with an initial set of Rules governing essential aspects of its operation, accompanied by six Practice Notes. The content and structure of these resources is quite different to the Practice Direction and Hearing Guidance materials for the former Board. They will provide detailed guidance to external parties regarding the practice and procedure of the Tribunal. The Rules and Practice Notes will be available on the Tribunal's website.

A variety of information products are being developed to assist access to information about the Tribunal for designated mental health services, consumers, carers and other parties. These information products will be on the Tribunal's website. The Tribunal's website will also link to other relevant websites; for example, the Office of the Mental Health Complaints Commissioner.

Case Study 7

P had been diagnosed with bipolar affective disorder. During her treatment as an inpatient, she had progressed well. At the time of hearing, P's treating team was still concerned with P's judgment but said P was almost ready for discharge as a voluntary patient. The treating team was especially concerned about certain financial decisions P had made while experiencing a manic episode.

The Board had to decide whether P had refused or was unable to consent to the necessary treatment for her illness. P had not refused the medication prescribed for her. Her treating team said P could provide informed consent to her medication, but could not manage her finances competently.

It was also argued the other treatment P needed was to be treated as an inpatient in hospital. The treating team submitted that P would leave hospital without an involuntary treatment order in place. P said she would stay in hospital as long as she needed treatment.

The Board considered the fact that P had not refused necessary treatment and she could make informed decisions about her medication. The Board decided this criterion was not satisfied and discharged P from her involuntary treatment order. Whether P could make competent financial decisions was not a factor to consider according to this criterion.

Under the new Act, the Tribunal will not consider whether a patient has refused or is unable to consent to necessary treatment. Under the new Act, a person is presumed to have capacity to consent to treatment and this presumption does not need to be rebutted for a person to be placed on a Treatment Order.

Financial Summary

The table below provides a summary of the Board's funding sources and expenditure for 2013/14. The Board'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 Board receives a government appropriation directly from the Department of Health.

Appropriation

	2013/14	2012/13	2011/12
TOTAL	<u>\$3,634,000</u>	<u>\$3,451,100</u>	<u>\$3,061,871</u>

Expenditure

Staff Salaries	\$777,940	\$785,434	\$770,544
Member Sitting Fees #1	\$2,022,264	\$1,849,951	\$1,585,526
Total Salaries and Member Fees	<u>\$2,800,204</u>	<u>\$2,635,385</u>	<u>\$2,356,070</u>
Salary Oncosts and Indirect Expenses	<u>\$424,232</u>	<u>\$393,901</u>	<u>\$368,925</u>
Member Mileage Allowance	\$191,747	\$189,894	\$177,830
External Printing	\$13,177	\$11,376	\$22,948
Voice Communication	\$26,299	\$23,393	\$22,272
Postage and Courier Services	\$24,785	\$48,595	\$50,500
Staff Development and Training	\$2,246	\$4,828	\$8,100
Interpreter Services	\$25,733	\$27,685	\$28,189
Miscellaneous Operating Expenses	\$140,866	\$93,032	\$84,986
Total Supplies and Consumables	<u>\$424,853</u>	<u>\$412,754</u>	<u>\$418,462</u>
TOTAL	<u>\$3,649,289</u>	<u>\$3,442,040</u>	<u>\$3,143,457</u>
Balance	<u>(\$15,289)</u>	<u>\$9,060</u>	<u>(\$81,586)</u>

#1 Member sitting fees for the Psychosurgery Review Board are included in this figure but are also identified separately: see page 25.

Appendix A

Membership List – Members of the Board for the year 2013/14

Legal Members

Member	Period of Appointment	Member	Period of Appointment
Mr Graeme Bailey	(21 February 1989 – 24 February 2016)	Ms Jo-Anne Mazzeo	(10 June 2013 – 9 June 2018)
Ms Pamela Barrand	(3 September 1996 – 9 June 2018)	Prof Bernadette McSherry	(5 September 2000 – 9 June 2018)
Ms Troy Barty	(1 June 2003 – 24 February 2016)	Ms Carmel Morfuni	(25 February 2006 – 24 February 2016)
Ms Wendy Boddison	(7 September 2004 – 9 June 2018)	Ms Anne O'Shea	(8 September 1987 – 9 June 2018)
Ms Venetia Bombas	(10 June 2013 – 9 June 2018)	Mr Robert Phillips	(29 June 1999 – 24 February 2016)
Mr Matthew Carroll*	(1 June 2003 – 16 May 2015)	Mr David Risstrom	(25 February 2006 – 24 February 2016)
Mr Andrew Carson	(3 September 1996 – 9 June 2018)	Ms Dominique Saunders	(1 June 2003 – 24 February 2016)
Dr Peter Condliffe	(10 June 2008 – 9 June 2018)	Mr Nick Sciola	(7 September 2004 – 9 June 2018)
Mr Robert Daly	(10 June 2013 – 9 June 2018)	Ms Janice Slattery	(25 February 2006 – 24 February 2016)
Ms Joan Dwyer	(25 February 2006 – 24 February 2016)	Ms Susan Tait	(10 June 2013 – 9 June 2018)
Dr David Eldridge	(10 June 2008 – 9 June 2018)	Dr Michelle Taylor-Sands	(10 June 2013 – 9 June 2018)
Dr Ian Freckelton	(23 July 1996 – 24 February 2016)	Dr Andrea Treble	(23 July 1996 – 24 February 2016)
Ms Susan Gribben	(5 September 2000 – 9 June 2018)	Ms Helen Versey	(10 June 2013 – 9 June 2018)
Mr Jeremy Harper	(10 June 2008 – 9 June 2018)	Ms Kara Ward	(10 June 2013 – 9 June 2018)
Mr Brook Hely	(25 February 2011 – 24 February 2016)	Ms Jennifer Williams	(7 September 2004 – 9 June 2018)
Ms Amanda Hurst	(10 June 2013 – 9 June 2018)	Ms Bethia Wilson	(10 June 2013 – 9 June 2018)
Ms Kylie Lightman	(10 June 2013 – 9 June 2018)	Ms Camille Woodward	(25 February 2011 – 24 February 2016)
Ms Kim Magnussen	(25 February 2011 – 24 February 2016)	Prof Spencer Zifcak	(8 September 1987 – 24 February 2016)
Mr Owen Mahoney	(10 June 2008 – 9 June 2018)		

Psychiatrist Members

Member	Period of Appointment	Member	Period of Appointment
Dr Robert Athey	(9 October 2012 – 8 October 2017)	Dr Jenny Lawrence	(9 October 2012 – 8 October 2017)
Dr David Baron	(22 January 2003 – 24 February 2016)	Dr Grant Lester	(11 March 2014 – 9 June 2018)
Dr Fiona Best	(10 June 2013 – 9 June 2018)	Dr Samantha Loi	(11 March 2014 – 9 June 2018)
Dr Joe Black	(11 March 2014 – 9 June 2018)	Dr Margaret Lush	(3 September 1996 – 9 June 2018)
Prof Sidney Bloch	(14 July 2009 – 9 June 2018)	Dr Barbara Matheson	(9 October 2012 – 8 October 2017)
Dr Pia Brous	(10 June 2008 – 9 June 2018)	Dr Peter McArdle	(14 September 1993 – 9 June 2018)
Dr Tom Callaly	(11 March 2014 – 9 June 2018)	Dr Cristea Mileschkin	(14 July 2009 – 9 June 2018)
Dr Susan Carey	(25 February 2011 – 24 February 2016)	Dr Robert Millard	(14 July 2009 – 9 June 2018)
Dr Eamonn Cooke	(14 July 2009 – 9 June 2018)	Dr Peter Millington	(30 October 2001 – 9 June 2018)
Dr Blair Currie	(9 October 2012 – 8 October 2017)	Dr Frances Minson	(30 October 2001 – 9 June 2018)
Dr Elizabeth Delaney	(25 February 2011 – 24 February 2016)	Dr Ilana Nayman	(9 October 2012 – 8 October 2017)
Dr Astrid Dunsis	(25 February 2006 – 24 February 2016)	Dr Nicholas Owens	(10 June 2013 – 9 June 2018)
Dr Leon Fail	(9 October 2012 – 8 October 2017)	Dr Gunvant Patel	(11 March 2014 – 9 June 2018)
Assoc. Prof. John Fielding	(11 March 2014 – 9 June 2018)	Dr Tom Peyton	(19 May 1998 – 24 February 2016)
Dr Stanley Gold	(10 June 2008 – 9 June 2018)	Dr Angelo Rodrigo	(13 February 2007 – 24 February 2016)**
Dr Yvonne Greenberg	(11 March 2014 – 9 June 2018)	Dr Philip Roy	(9 October 2012 – 8 October 2017)
Dr Fintan Harte	(13 February 2007 – 24 February 2016)	Dr Joanna Selman	(11 March 2014 – 9 June 2018)
Assoc. Prof. Anne Hassett	(11 March 2014 – 9 June 2018)	Dr John Serry	(14 July 2009 – 9 June 2018)
Dr Harold Hecht	(9 October 2012 – 8 October 2017)	Dr Anthony Sheehan	(10 June 2008 – 9 June 2018)
Dr Michael Jonas	(9 October 2012 – 8 October 2017)**	Dr Frederick Stamp	(1 June 2003 – 24 February 2016)
Dr Sylvia Jones	(27 July 2010 – 26 July 2015)	Dr Jan Steel	(27 July 2010 – 26 July 2015)
Dr Stephen Joshua	(27 July 2010 – 26 July 2015)	Dr Barbara Taylor	(4 November 1987 – 9 June 2018)
Dr Spridoula Katsenos	(9 October 2012 – 8 October 2017)	Dr Jennifer Torr	(11 March 2014 – 9 June 2018)
Dr Miriam Kuttner	(7 September 2004 – 9 June 2018)	Dr Maria Triglia	(25 February 2011 – 24 February 2016)
Dr Stella Kwong	(29 June 1999 – 24 February 2016)	Assoc. Prof. Ruth Vine	(9 October 2012 – 8 October 2017)

Community Members

Member	Period of Appointment	Member	Period of Appointment
Dr Lisa Brophy	(10 June 2008 – 9 June 2018)	Mr Gordon Matthews	(7 September 2004 – 9 June 2018)
Mr Duncan Cameron	(10 June 2008 – 9 June 2018)	Dr Marilyn McMahon	(19 December 1995 – 24 February 2016)
Dr Leslie Cannold	(10 June 2013 – 9 June 2018)	Dr Kylie McShane	(29 June 1999 – 24 February 2016)
Ms Lynne Coulson Barr	(1 June 2003 – 24 February 2016)**	Dr Patricia Mehegan	(10 June 2008 – 9 June 2018)
Mr Ashley Dickinson	(25 February 2011 – 24 February 2016)	Ms Helen Morris	(20 April 1993 – 24 February 2016)
Ms Robyn Duff	(25 February 2011 – 24 February 2016)	Ms Margaret Morrissey	(25 February 2011 – 24 February 2016)
Ms Sara Duncan	(10 June 2013 – 9 June 2018)	Mr Jack Nalpantidis	(23 July 1996 – 24 February 2016)
Ms Margaret Fowler	(25 February 2011 – 24 February 2016)	Ms Liza Newby	(14 September 1996 – 9 June 2018)
Ms Liz Gallois	(5 September 2000 – 9 June 2018)	Ms Linda Rainsford	(10 June 2013 – 9 June 2018)
Mr John Griffin	(25 February 2011 – 24 February 2016)	Ms Lynne Ruggiero	(10 June 2013 – 9 June 2018)
Ms Patricia Harper	(5 September 2000 – 9 June 2018)	Dr Diane Sisely	(25 February 2006 – 24 February 2016)
Adj. Prof. Bill Healy	(5 September 2000 – 9 June 2018)	Mr Fionn Skiotis	(25 February 2006 – 24 February 2016)
Mr Ben Ilsley	(10 June 2013 – 9 June 2018)	Dr Jim Sparrow	(7 September 2004 – 9 June 2018)
Mr John King	(1 June 2003 – 24 February 2016)	Ms Veronica Spillane	(25 February 2011 – 24 February 2016)
Ms Danielle Le Brocq	(10 June 2013 – 9 June 2018)	Ms Charlotte Stockwell	(10 June 2013 – 9 June 2018)
Mr John Leatherland	(25 February 2011 – 24 February 2016)	Professor Trang Thomas	(10 June 2013 – 9 June 2018)
Dr Margaret Leggatt	(10 June 2013 – 9 June 2018)	Ms Helen Walters	(10 June 2013 – 9 June 2018)
Ms Fiona Lindsay	(5 September 2000 – 9 June 2018)	Dr Penny Webster	(25 February 2006 – 24 February 2016)
Dr David List	(25 February 2006 – 24 February 2016)	Dr Penelope Weller	(10 June 2013 – 9 June 2018)
Ms Anne Mahon	(10 June 2013 – 9 June 2018)		

* President from 17 May 2010

** Resignation is currently with Governor-in-Council

Appendix B

Educational Activities 2013/14

Date	Organisation/Seminar/Conference	Title of Presentation/Course Session Title
12 August 2013	NorthWestern Mental Health	Mental Health Act in Clinical Practice: Role and Functions of the Mental Health Review Board
13 August 2013	South West Healthcare (Warrnambool)	Making compulsory orders: the role of the Mental Health Tribunal as primary decision maker
15 August 2013	Albert Road Clinic	Mental Health Act – Outline of Key Reform Themes
24 October 2013	Victorian Mental Illness Awareness Council	Consumer Workforce Presentation
25 February 2014	North-Western Mental Health	Mental Health Act in Clinical Practice: Role and Functions of the Mental Health Review Board
04 March 2014	Health Education Australia Limited – ECT re-accreditation course	ECT and the Mental Health Tribunal
13 March 2014	Victorian Mental Health Carer's Network (now Tandem)	Reform of the Mental Health Act: the role and operation of the Mental Health Tribunal
18 March 2014	Australian Nursing and Midwifery Federation	Mental Health Act Implementation Forum
14 May 2014	Melbourne Clinic	The role of the Mental Health Tribunal under the <i>Mental Health Act 2014</i>
20 May 2014	Eastern Health	Training Forum
16 June 2014	Victoria Legal Aid	Advocates Training Program
18 June 2014	MHA Clinical Leadership Forum	Moving from compliance to engagement – integrating the functions of the Mental Health Tribunal within the provision of support and treatment to compulsory patients
19 June 2014	Australian Medical Association Victoria	The role of the Mental Health Tribunal under the <i>Mental Health Act 2014</i>
27 June 2014	Mental Health Complaints Commissioner	Staff Training Program

Appendix C

Compliance Reports

In 2013/14, the Board maintained its existing policies and procedures concerning the *Freedom of Information Act 1982*, the *Protected Disclosure Act 2012* and its records disposal authority under the *Public Records Act 1973*.

Application and operation of the Freedom of Information Act 1982

Victoria's *Freedom of Information Act 1982* (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 two main categories of information normally requested under the FOI Act are individuals asking for their personal documents and documents relating to the activities of the Board. It should be noted that certain documents may be destroyed or transferred to the Public Records Office in accordance with the *Public Records Act 1973*.

Where possible, the Board provides information administratively without requiring a freedom of information request. This financial year, the board received one request under the FOI Act. The information that was the subject of the request was personal information that related to the application; the Board therefore released the documents administratively.

How to lodge a request

Information previously held by the Board is now held by the Mental Health Tribunal. The public is encouraged 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, must clearly identify the documents being requested, and be accompanied by the application fee which from 1 July 2014 is \$26.50. The request should be addressed to:

The FOI Officer
Mental Health Tribunal
Level 30, 570 Bourke Street
Melbourne Vic 3000
Phone: (03) 9032 3200
email: mht@mht.vic.gov.au

The Mental Health Tribunal has developed a comprehensive guide to freedom of information.

It can be accessed at <http://www.mht.vic.gov.au/information-about/freedom-of-information-and-protected-disclosures/>.

Further information regarding freedom of information, including current fees, can be found at www.foi.vic.gov.au.

Application and operation of the Protected Disclosure Act 2012

The *Protected Disclosure Act 2012* encourages and facilitates disclosures of known or suspected improper conduct of public officers, public bodies and other persons and disclosures of detrimental action taken in reprisal for a person making a disclosure under the Act.

The 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 provides for the investigation of disclosures that meet the definition of a protected disclosure.

Disclosures about improper conduct can be made by employees or by any member of the public.

During the 2013/14 financial year, the Board did not receive any disclosures of improper conduct.

How to make a disclosure

Disclosures of improper conduct of the Board or its staff can be made verbally or in writing (but not by fax) as follows.

Disclosures about Board staff (now Mental Health Tribunal staff):

Protected Disclosure Coordinator
Department of Health
50 Lonsdale Street
Melbourne VIC 3000
Telephone: 1300 045 866
Email: protected.disclosure@health.vic.gov.au
www.health.vic.gov.au/whistle-fraud.htm

Disclosures can also be made directly to the Independent Broad-based Anti-corruption Commission (IBAC). However, disclosures about a Board member (now Tribunal member) or the Board (now Tribunal) as a whole, must be made directly to IBAC.

IBAC's contact details are:

Level 1, North Tower
459 Collins Street
Melbourne VIC 3000
GPO Box 24234
Melbourne VIC 3001
Telephone: 1300 735 135
www.ibac.vic.gov.au

The Mental Health Tribunal has developed a comprehensive guide to protected disclosures. It can be accessed at <http://www.mht.vic.gov.au/information-about/freedom-of-information-and-protected-disclosures/>.

Further information regarding protected disclosures can be found at www.ibac.vic.gov.au.

2013 / 2014 Annual Report

Psychosurgery Review Board

Overview	23
The role of the Psychosurgery Review Board	23
Structure of the Psychosurgery Review Board	23
Psychosurgery Review Board Members	23
Chairperson's Message	24
Activities of the Board during 2013/14	25
Applications to perform psychosurgery	25
Financial Summary	25
Appendix A	26
Mental Health Tribunal Practice Note 6 – Applications to perform neurosurgery	
Appendix B	28
Compliance Reports	

PSYCHOSURGERY REVIEW BOARD

Level 30, Marland House,
570 Bourke Street,
Melbourne Victoria 3000
DX 210222 Melbourne
Internet: www.prb.vic.gov.au
Email: prb@prb.vic.gov.au
Telephone : 03 8601 5270
Facsimile: 03 8601 5299
Vic Toll Free: 1800 242 703

12 August 2014

The Honourable Mary Wooldridge MP
Minister for Mental Health
Department of Health
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

Dear Minister

I am pleased to present the Psychosurgery Review Board's final annual report of its operations for the period 1 July 2013 to 30 June 2014.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Matthew Carroll', with a stylized flourish at the end.

Matthew Carroll
Chairperson

Overview

The Role of the Psychosurgery Review Board

The Psychosurgery Review Board (the Board) was established by s56 of the *Mental Health Act 1986* (the Act). The role of the Board is to determine applications by psychiatrists for a neurosurgeon to perform psychosurgery on a person. To protect confidentiality, Board hearings are closed to the public.

Structure of the Psychosurgery Review Board

Schedule 3 to the Act sets out the procedure for appointments to the Board, the membership of the Board and the qualifications for membership. The Board consists of four members appointed by the Governor-in-Council on the recommendation of the Minister for Mental Health. Alternative members are also appointed to act during the absence or illness of a member. The Board must be made up of both males and females and consist of:

- (a) a person who has been admitted to legal practice, in Victoria or elsewhere in Australia, for not less than five years; and
- (b) a person who is a neurosurgeon nominated by the Royal Australasian College of Surgeons; and
- (c) a person who is a psychiatrist nominated by the Minister for Mental Health; and
- (d) a person who is a psychiatrist nominated by the Royal Australian and New Zealand College of Psychiatrists; and
- (e) a person who is a member of the public nominated by the Victorian Council for Civil Liberties Inc.

The Board has no full-time staff. It operates from the offices of the Mental Health Review Board, and the Mental Health Review Board's Executive Officer and Legal Officer provide operational and administrative support to the Board as required.

Psychosurgery Review Board Members for the period 1 July 2013 – 30 June 2014

Members	Appointed From	Appointed Until
Legal Members		
Mr Matthew Carroll (<i>Chairperson</i>)	27 June 2010	30 June 2014
Dr Ian Freckelton (<i>Alternative</i>)	27 June 2010	30 June 2014
Psychiatrists – Ministerial Nominees		
Dr Dennis Velakoulis (<i>Deputy Chairperson</i>)	2 December 2008	30 June 2014
Prof Daniel O'Connor (<i>Alternative</i>)	27 June 2010	30 June 2014
Psychiatrists – College Nominees		
Assoc Prof Malcolm Hopwood (<i>Alternative</i>)	5 September 2010	30 June 2014
Neurosurgeons		
Professor Jeffrey Rosenfeld	28 March 2006	30 June 2014
Mr Peter McNeill (<i>Alternative</i>)	27 June 2010	30 June 2014
Civil Liberties Representatives		
Mr Jamie Gardiner	19 December 1993	30 June 2014
Dr Diane Sisely (<i>Alternative</i>)	28 March 2006	30 June 2014

Chairperson's Message

Continuing a somewhat stable pattern from previous years, this year the Psychosurgery Review Board (Board) approved four applications to perform psychosurgery. All applications concerned deep-brain stimulation, three were for the treatment of obsessive compulsive disorder, and one was for treatment-resistant depression. The individuals for whom treatment was approved came from Victoria and New South Wales.

One application was to undertake a second surgical intervention for a person who had already been treated with deep-brain stimulation. While the person had initially experienced a significant reduction in symptoms, and had been able to re-engage socially and return to the workforce, this was not sustained and those gains diminished over time. Based on research findings, the treating team proposed targeting a different region of the brain. Following a thorough examination of the case, with a particular focus on whether the person had capacity to provide informed consent, and whether the procedure was appropriate and had clinical merit, the Board granted approval for the procedure.

This will be the final annual report of the Psychosurgery Review Board. When the *Mental Health Act 2014* commences on 1 July 2014 the Board will cease to exist. The new Act will still set down a process for approval of psychosurgery – which will be called neurosurgery for mental illness (NMI) – and this will be part of the jurisdiction of the Mental Health Tribunal. Unlike the Board the Tribunal will not receive reports on the performance of NMI. In future, those reports will be provided to the Chief Psychiatrist.

As always I wish to thank the members of the Board who, within extremely busy schedules, have made themselves available to conduct hearings during the year. Professor Jeffrey Rosenfeld and Mr Peter McNeill, the Board's neurosurgeon members, have provided an invaluable perspective in hearings and will complete their appointments on 30 June. The Tribunal will not have neurosurgeon members, but will have the capacity to engage a person to provide expert advice in relation to any matter arising in a proceeding. This will provide ongoing neurosurgical input when required.

Professors Hopwood, O'Connor and Velakoulis will continue as psychiatrist members of the Tribunal. They have kindly offered to sit on NMI hearings and provide support to other members as the Tribunal integrates the functions of the Psychosurgery Review Board within its other functions. Professor Freckelton and Dr Sisely are, respectively, legal and community members of the Tribunal, while Mr Gardiner has retired.

The Tribunal will therefore be well equipped to undertake its responsibilities in relation to NMI retaining the benefit of much of the expertise that resided in the Psychosurgery Review Board. In addition, there will be the added advantage of a higher degree of flexibility with regard to convening divisions to conduct hearings. This will enable the thorough, effective and timely handling of this numerically small, but critically important category of applications.

Matthew Carroll
Chairperson

Activities of the Board during 2013/14

Applications to perform psychosurgery

Psychosurgery is defined by s54 of the Act to include:

- (a) any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; or
- (b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; or
- (c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of influencing or altering the thoughts, emotions or behaviour of that person.

Over the reporting period, all applications to perform psychosurgery related to a procedure known as deep-brain stimulation, which falls within the third limb of the above definition.

In order to grant consent for the performance of psychosurgery, the Board must be satisfied in relation to the following matters:

- that the person for whom psychosurgery is being proposed is capable of giving, and has given, informed consent;
- that the proposed psychosurgery has clinical merit and is appropriate;
- that the doctors involved are properly qualified and experienced in the field;
- that the hospital where the procedure will be performed (if approved) is an appropriate place for the procedure to be performed; and
- that all other reasonable treatments have already been adequately and skilfully administered without sufficient and lasting benefit.

In 2010 the Board issued detailed guidelines to assist applicant psychiatrists provide all relevant information to the Board prior to a hearing being convened. These guidelines were designed to ensure that the Board was furnished with all the information it needed to decide whether to consent to psychosurgery, and to facilitate the expeditious determination of applications. These guidelines set out the

minimum requirements for information regarding clinical and treatment history and minimised the risk of applications having to be adjourned while additional information was gathered to enable the Board to make a decision. These guidelines have formed the basis of the Mental Health Tribunal's practice note relating to applications to perform neurosurgery for mental illness, a copy of which is reproduced at Appendix A.

Table 1: Applications handled by the Board during 2013/2014

Applications carried over from previous financial year 2012/2013	1
Applications received 2013/2014	3
Applications heard 2013/2014	4
Applications approved	4
Applications declined	0

Table 2: Applications received from financial years 1988-2013

Year	Applications received
1988	2
1989	1
1990	2
1991	2
1992	1
1993	2
1994	nil
1995	1
1996	3
1997	nil
1998	nil
1999	1
2000	1
2001	nil
2002	nil
2003	nil
2004	nil
2005	nil
2006	nil
2007	1
2008	2
2009	1
2010	5
2011	1
2012	2
2013	3
2014	3

Financial Summary

The table below provides a summary of the Board's funding sources and expenditure for 2013/14. The Board's full audited accounts are published as part of the accounts of the Department of Health in its annual report.

The Board has no staff and operates from the offices of the Mental Health Review Board. The Mental Health Review Board's Executive Officer and Legal Officer provide operational and administrative support to the Board as required. Given that the Board does not receive a government appropriation, and operates using the Mental Health Review Board's offices and staff, the following table reflects only the specific and easily identifiable costs associated with the Board's hearing process, which are, essentially, the fees paid to members for sitting on hearings.

Expenditure

	2013/14	2012/13	2011/12
Member	\$7,868	\$3,372	\$2,740
Sitting Fees			

Appendix A

Mental Health Tribunal Practice Note 6 – Applications to perform neurosurgery

I. PRELIMINARY

1. This Practice Note has been issued by the Rules Committee of the Mental Health Tribunal in accordance with section 209(1) of the Mental Health Act 2014.

Introduction and purpose

2. The Mental Health Tribunal has decision making functions with respect to a range of hearing types under the Act.
3. Under section 100(2), a psychiatrist may apply to the Tribunal for approval to arrange for the performance of neurosurgery for mental illness on a person if the person has personally given informed consent in writing to the performance of neurosurgery on himself or herself.
4. The Tribunal must hear and determine an application made under section 100(2) within 30 business days after receipt of that application.
5. The Tribunal must not grant an application unless it is satisfied that the person in respect of whom the application is made has given informed consent in writing to the performance of neurosurgery for mental illness on himself or herself and the performance of neurosurgery for mental illness will benefit the person.
6. In determining whether the neurosurgery will benefit the person, the Tribunal is required to consider the matters specified in section 102(3).
7. The Tribunal requires the psychiatrist who made the application, to give the Tribunal a report in order to assist the Tribunal to consider the matters it is required to consider under the Act.
8. To this end, the purpose of this Practice Note is to assist psychiatrists to provide the report required to assist the Tribunal to make its determination. It describes the minimum information relevant to the particular application for review.

Scope of application

9. This Practice Note applies to a psychiatrist who has applied to the Tribunal for approval to arrange for the performance of neurosurgery for mental illness under section 100(2).
10. The guidance in this Practice Note does not exhaustively determine the matters which the psychiatrist may provide to the Tribunal. In each case, the Tribunal may require the psychiatrist to provide further information and/or attend the hearing of the application.

Commencement date

11. This Practice Note takes effect on 1 July 2014.

Definitions

12. Unless otherwise specified, all references to sections in this Practice Note are to sections of the *Mental Health Act 2014*.
13. Unless otherwise specified, terms in this Practice Note have the same meaning as in the Act.
14. In particular, readers of this Practice Note should understand the following definitions:
 - 14.1 *'capacity to give informed consent'* as defined at section 68 of the Act
 - 14.2 *'informed consent'* as defined at section 69 of the Act;
 - 14.3 *'neurosurgery for mental illness'* is defined at section 3 of the Act.
15. This Practice Note may be referred to as *'PN 6 - Applications to perform neurosurgery'*.

II. CONTENT OF REPORT

16. Where an application is made under section 100(2), the psychiatrist must provide a report to the Tribunal that contains the following information that clearly identifies:

Identifying details

- 16.1 The applicant psychiatrist's:
 - (a) name; and
 - (b) address for service;
- 16.2 With respect to the person who is the subject of the application, that person's –
 - (a) name;
 - (b) residential address and/or other address for service;
 - (c) date of birth;
 - (d) usual occupation;
 - (e) name and address of the person's carer (if applicable);
 - (f) name and address of the person's treating psychiatrist;

Information concerning the person upon whom it is proposed to perform neurosurgery

- 16.1 Details of the person who is the subject of the application's capacity to give informed consent to the proposed neurosurgery for mental illness;
- 16.2 Details of whether the person who is the subject of the application has given informed consent to the performance of neurosurgery on himself or herself, including the process that has been followed and the information provided to obtain the patient's informed consent;
- 16.3 Details of who will perform the neurosurgery for mental illness and where it will be performed;
- 16.4 Details of who will be the members of the patient's treating team leading up to and following surgery;
- 16.5 Particulars of the exact nature of the neurosurgery for mental illness proposed to be performed; and
- 16.6 Whether the patient's treatment is part of a research program and, if so, what the details of this are;

Information concerning the benefit of neurosurgery

- 16.7 Detailed reasons as to why the psychiatrist considers that the proposed neurosurgery for mental illness will benefit the person, having regard to each of the following:
 - (a) whether neurosurgery for mental illness is likely to remedy the mental illness or alleviate the symptoms and reduce the ill-effects of the mental illness;
 - (b) the likely consequences for the person if neurosurgery for mental illness is not performed;
 - (c) any beneficial alternative treatments that are reasonably available and the person's views and preferences about those treatments; and
 - (d) the nature and degree of any discomfort, risks and common or expected side-effects associated with the proposed neurosurgery for mental illness, including the person's views and preferences about any such discomfort, risks or common or expected side-effects;

Include attachments with the report

- 16.8 Details of assessments that have been undertaken in order to reach the decision to apply to perform neurosurgery;
- (a) Attach all relevant reports and results of investigations from treating psychiatrists and other persons, and include a full psychiatric history; and
 - (b) See following paragraph for a list of the relevant assessments;
- 16.9 The psychiatrist must attach to the report a copy of the following documents:
- (a) The written informed consent of the person who is the subject of the application in the form of the Tribunal's Template *'Consent to performance of neurosurgery for mental illness'*;
 - (b) Any medical test results for the person who is the subject of the application; including, if available:
 - (i) full blood count (including ESR, electrolytes and creatinine);
 - (ii) skull and chest X-rays;
 - (iii) EEG results;
 - (iv) brain imaging;
 - (v) thyroid function test results;
 - (vi) liver function test results;
 - (vii) Vitamin B12 and folate;
 - (viii) syphilis serology results; and
 - (ix) AIDS antibody testing.
 - (c) Any psychological test results; including (if applicable) the result of:
 - (i) IQ tests;
 - (ii) personality or neuropsychological tests;
 - (iii) depression and anxiety ratings, performed by persons who are skilled in the administration and interpretation of those instruments;
 - (d) Details of previous treatments that have been tried to alleviate the condition for which it is proposed to perform the neurosurgery including all treating details and responses, including the chronology, dosage, combination, duration of treatment procedures, the responsible clinician's name, place of administration and response carer;
 - (i) Antidepressants (including SSRI, SNRI, MAOI, NARI, Tricyclic and Tetracyclics);
 - (ii) prescribed medications; particularly, antipsychotics and mood stabilisers, clomibramine (in the case of a person who has been diagnosed with Obsessive-Compulsive Disorder);
 - (iii) Electroconvulsive treatment (unilateral and bilateral);
 - (iv) Psychotherapy, including cognitive behaviour therapy, interpersonal therapy, transcranial magnetic stimulation (rTMS) or any other treatment;
 - (e) clinical notes of all significant inpatient admissions relevant to the application, or if not practicable to provide such notes, accurate and detailed chronological summaries of those notes;
 - (f) detailed reports from all medical and allied health professionals who have provided significant treatment and care for the patients during periods relevant to the application, which include:
 - (i) accurate and detailed chronological summaries of all pharmacological, psychiatric, psychological and other treatments provided to the patient;
 - (ii) detailed reports from all treating practitioners, including consultant psychiatrists, psychologists and all other allied health professionals, including:
 - (A) any mental state, treatment or other relevant assessments given; and
 - (B) outlining their involvement in the patient's treatment;
 - (g) accurate and detailed chronological summaries of the clinical notes of all significant inpatient admissions relevant to the application;
 - (h) detailed report(s) from at least one of the leading clinicians containing, with respect to the person who is the subject of the application, an accurate and detailed:
 - (i) chronological developmental history;
 - (ii) chronological past psychiatric and co-morbid psychiatric history;
 - (iii) chronological pharmacotherapy and treatment history relevant to the application, including:
 - (A) names of medications;
 - (B) combinations of medications;
 - (C) dosages of medications;
 - (D) dates and periods of use;
 - (E) changes to the medications and the dates of those changes;
 - (F) cessation of the treatment and the dates of the cessation;
 - (G) symptom response and benefits, and periods of symptom response and benefits;
 - (H) side-effects and adverse reactions;
 - (I) periods of side-effects and adverse reactions;
 - (J) clinical indications; and
 - (K) reasons for decisions to change and/or cease medications;
 - (i) a detailed and comprehensive report and assessment from an independent psychiatrist who:
 - (i) is considered a leading expert in the management of the psychiatric disorder(s) relevant to the application; and
 - (ii) has personally examined the person who is the subject of the application.

III. IMPORTANT NOTICE

17. Psychiatrists who propose to apply to the Tribunal under section 100(2) should note:
- 17.1 The Tribunal has prepared an application form for applications under section 100(2);
 - 17.2 A copy of the application form and attachments provided in support of the application will be provided to the person who is the subject of the application; and
 - 17.3 under section 104, the psychiatrist who made the application, or the psychiatrist treating the person following the neurosurgery for mental illness, must provide a written report to the chief psychiatrist on the results of the neurosurgery for mental illness. The report must be given to the chief psychiatrist within 3 months after the surgery is performed and within 9 to 12 months after the surgery is performed.
 - 17.4 Under section 13, the psychiatrist must ensure that a statement of rights is given to the person and that the person also receives an oral explanation of the statement of rights.
17. Reports, all attachments and the signed consent form must be provided to the Tribunal at the same time as the application or as otherwise directed by the Tribunal.

Appendix B

Compliance Reports

In 2013/14, the Board maintained its existing policies and procedures concerning the *Freedom of Information Act 1982*, the *Protected Disclosure Act 2012* and its records disposal authority under the *Public Records Act 1973*.

Application and operation of the Freedom of Information Act 1982

Victoria's *Freedom of Information Act 1982* (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 two main categories of information normally requested under the FOI Act are individuals asking for their personal documents and documents relating to the activities of the Board. It should be noted that certain documents may be destroyed or transferred to the Public Records Office in accordance with the *Public Records Act 1973*.

Where possible, the Board provides information administratively without requiring a freedom of information request. The Psychosurgery Review Board did not receive any requests for the reporting period.

How to lodge a request

Information previously held by the Board is now held by the Mental Health Tribunal. The public is encouraged to contact the Tribunal before lodging a request under the FOI Act to ascertain if the documents can be released administratively.

Otherwise, a freedom of information request must be made in writing, must clearly identify the documents being requested, and be accompanied by the application fee which from 1 July 2014 is \$26.50. The request should be addressed to:

The FOI Officer
Mental Health Tribunal
Level 30, 570 Bourke Street
Melbourne Vic 3000
Phone: (03) 9032 3200
email: mht@mht.vic.gov.au

The Mental Health Tribunal has developed a comprehensive guide to freedom of information. It can be accessed at <http://www.mht.vic.gov.au/information-about/freedom-of-information-and-protected-disclosures/>.

Further information regarding freedom of information, including current fees, can be found at www.foi.vic.gov.au.

Application and operation of the Protected Disclosure Act 2012

The *Protected Disclosure Act 2012* encourages and facilitates disclosures of known or suspected improper conduct of public officers, public bodies and other persons and disclosures of detrimental action taken in reprisal for a person making a disclosure under the Act.

The 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 provides for the investigation of disclosures that meet the definition of a protected disclosure.

Disclosures about improper conduct can be made by employees or by any member of the public.

During the 2013/14 financial year, the Board did not receive any disclosures of improper conduct.

How to make a disclosure

Disclosures of improper conduct of the Board or its staff can be made verbally or in writing (but not by fax) as follows.

Disclosures about Board staff (now Mental Health Tribunal staff):

Protected Disclosure Coordinator
Department of Health
50 Lonsdale Street
Melbourne VIC 3000
Telephone: 1300 045 866
Email: protected.disclosure@health.vic.gov.au
www.health.vic.gov.au/whistle-fraud.htm

Disclosures can also be made directly to the Independent Broad-based Anti-corruption Commission (IBAC). However, disclosures about a Board member (now Tribunal member) or the Board (now Tribunal) as a whole, must be made directly to IBAC.

IBAC's contact details are:

Level 1, North Tower
459 Collins Street
Melbourne VIC 3000
GPO Box 24234
Melbourne VIC 3001
Telephone: 1300 735 135
Website: www.ibac.vic.gov.au

The Mental Health Tribunal has developed a comprehensive guide to protected disclosures. It can be accessed at <http://www.mht.vic.gov.au/information-about/freedom-of-information-and-protected-disclosures/>.

Further information regarding protected disclosures can be found at www.ibac.vic.gov.au.

Mental Health Review Board

Level 30, Marland House
570 Bourke Street
Melbourne Victoria 3000
Phone: (03) 8601 5270
Email: mhrb@mhrb.vic.gov.au
Fax: (03) 8601 5299
Vic Toll Free: 1800 242 703
DX 210222 Melbourne
www.mhrb.vic.gov.au

Psychosurgery Review Board

Level 30, Marland House
570 Bourke Street
Melbourne Victoria 3000
Phone: (03) 8601 5270
Email: prb@prb.vic.gov.au
Fax: (03) 8601 5299
Vic Toll Free: 1800 242 703
DX 210222 Melbourne
www.prb.vic.gov.au

