Appendix 1: Constructive inquiry, clarification and reflection - the role of the Mental Health Tribunal in relation to treatment[1]

The facilitation of solution-focused hearings unavoidably requires engagement with the question "what is the Tribunal's role in relation to treatment?" The Tribunal does have a legitimate role in relation to treatment but the nature and scope of that role is a complex issue, and one that needs to be understood and approached consistently.

1 The Tribunal and the Treatment Space

It was often said of the former Mental Health Review Board that it sat outside the treatment space. Whether this was ever an accurate statement is debatable, but it is entirely incorrect in relation to the Tribunal. This is so for multiple reasons.

1.1 The active role vested in the Tribunal

Admittedly we are comparing two sides of the one coin, and it is potentially a difference that can be exaggerated, but it is meaningful and significant that the former Board was a review body, in contrast to the Tribunal which is a primary decision maker. Whereas previously it was the authorised psychiatrist (or her or his delegate) who made Treatment Orders, now it is the Tribunal that takes the active role of intervening to make a Treatment Order. It is the Tribunal that decides to restrict an individual's autonomy and compel them to have treatment. When the Tribunal's role is understood in this way, arguably the key question is not whether the Tribunal has a role or interest in treatment, but rather how could the Tribunal not ask about or have an interest in the treatment that will be provided under a proposed Order?

Charged with the responsibility of making Treatment Orders we must understand what treatment we are compelling a person to accept, and we must be satisfied that the treatment, understood holistically (in other words, it extends beyond medication) meets certain minimum standards, namely those that are expressed in the mental health principles. This derives from:

- the *quid pro quo* of Treatment Orders, that is. a person will receive appropriate treatment in return for the limitation on their autonomy that flows from the making of a Treatment Order; and
- that Treatment Orders are in fact *a compact* with obligations on both parties – the patient is required to comply with treatment and the treating team to provide it. Related to this is the entitlement of a compulsory patient to have a very clear understanding of the treatment that will be provided and by whom, given the serious consequences that can flow from non-compliance.

It also arises from the treatment criteria and the definition of treatment set down in the *Mental Health Act 2014* (the Act). The third treatment criterion requires the Tribunal to be satisfied that a person will receive immediate treatment if they are subject to a Treatment Order. And 'treatment' is defined as:

> things done in the course of the exercise of professional skills —
> (i) to remedy the person's mental illness; or

(ii) to alleviate the symptoms and reduce the ill effects of the person's mental illness

While the Tribunal's role must not be misunderstood as being that of a treatment decision maker, the performance of its role under the Act extends beyond simply confirming that treatment 'of some sort' will occur if an Order is made. The Tribunal must understand the scope of proposed treatment and if matters are unclear or seem incomplete it must inquire further. The consideration of and discussion about all these matters must be informed by the preferences and views of patients, who must be given time and space to express those views not just to the Tribunal but also to their treating team.

1.2 The specific decisions being made by the Tribunal

Moving beyond the global description of the Tribunal's role as a primary decision maker to examine specific decisions made by the Tribunal reinforces that treatment – both what it does and doesn't include - is an essential consideration and something the Tribunal is obliged to scrutinise. Four examples spanning both Treatment Orders and ECT Orders illustrate this point:

a) When the Tribunal makes a Treatment Order it must decide whether it commences as an Inpatient or a Community Treatment Order. Under section 55(3) of the Act the Tribunal can only make an Inpatient Treatment Order if satisfied a person's treatment cannot occur within the community. Of course the level of scrutiny or exploration this requires will be dependent on the circumstances of each individual. However, if the Tribunal is being asked to make an Inpatient Treatment Order it must understand what specific elements of inpatient treatment are regarded as necessary at the time of the hearing and why this is the case.

b) When a Treatment Order is made the Tribunal must also determine its maximum duration. The Act does not set down a specific test to apply to determine duration, instead it specifies maximum durations for Inpatient and Community Treatment Orders, and otherwise leaves the matter to be decided by the Tribunal. Regarding its approach the Tribunal has always been clear that the maximum durations specified in the Act are just that – maximums – and not default durations. Duration is to be determined according to the circumstances of each individual and the proposed treatment plan – that is, how is the Order going to be used to support a person, and what is the rationale for that support needing to be provided compulsorily for the proposed period of time? In the absence of a very clear picture regarding what treatment is to be provided there is no logical basis for a Treatment Order of any more than a short duration.

c) The Tribunal requires services to prepare clinical reports before hearings and provides templates to assist them to do so. Version two of the ECT clinical report templates added a specific question confirming whether or not the different forms of ECT have been discussed with a patient, and if not why not. Given it is not the Tribunal's role to decide what type of ECT will be administered pursuant to an ECT Order, some might question the relevance of this inquiry. The basis of the question is that the Act casts a very wide net when it defines the information relevant to a particular decision[2], which in turn places a significant obligation on treating teams to provide information to and discuss information with patients and their support person. So while it is true that the Tribunal does not decide what type

of ECT will be administered, we have an obligation to ensure the different forms of ECT have been discussed with a patient, including the rationale for proposing one type of ECT over another. If this hasn't occurred (and it is not a situation where a patient is incapable of any level of discussion about ECT) there is a real question as to whether the Tribunal can be satisfied in relation to either of the criteria applicable to ECT Orders.

d) Finally, and again in relation to ECT, possibly no single provision of the Act draws the Tribunal more directly into the treatment space than the requirement to decide whether or not there is no less restrictive way for a person to be treated other than with ECT. This second criterion governing ECT Orders requires consideration of a broad range of matters, including (but not limited to):

- the person's current treatment
- why it is regarded as insufficient / ineffective
- whether a reasonable period of time has been allowed for the current treatment to work
- the alternatives and how long they might take to provide relief.

The above list is not intended to suggest ECT is to be regarded as a treatment of last resort – that is not legally correct – the point is the extent to which the Tribunal must explore the actual treatment and treatment options for a particular person.

1.3 The mental health principles

As with all other entities and individuals that work under the Act, the Tribunal is obliged to consider and promote the mental health principles. The principles must inform our interpretation of the Act and how we apply the criteria to individuals having a Tribunal hearing. This is not an abstract exercise, the mental health principles only find meaning in patients' and carers' day-to-day experience of the mental health system (including their experience of Tribunal hearings) – the what and the how of their actual treatment.

Exploration and promotion of the principles inherently requires scrutiny of treatment.

- In the absence of a clear picture regarding current and proposed treatment it is not possible to ensure treatment is the least restrictive possible, that it is recovery-oriented and that there is a focus on supported decision making (section 11(1)(a)-(c) and (e)).
- The practical implications of the principle of dignity of risk can only be understood if the degree of risk is clearly articulated and substantiated and the link to proposed treatment is clear (section 11(d)).
- Ensuring treatment is responsive to the particular needs of individuals from marginalised or vulnerable groups, and holistic in terms of a person's medical and other health needs, requires treatment plans that are framed around an individual and their circumstances, including, but extending beyond the particular symptoms of their mental illness (section 11(1)(f)-(j)).

1.4 The Tribunal's obligation as a public authority under the Charter of Human Rights and Responsibilities

Essentially, the Charter of *Human Rights and Responsibilities Act 2006* (the Charter) needs to be understood as raising the bar and bringing a particular focus to the scrutiny that must be applied to compulsory treatment. Compulsory treatment is undeniably a limitation on a person's human rights, but a limitation is not automatically a breach. What distinguishes a permissible limitation from a breach is where the limit is reasonable and directed to a legitimate purpose. To assess reasonableness and legitimacy the Tribunal must thoroughly scrutinise the applicability of the treatment criteria and/or the ECT criteria to an individual. This obligation can only be discharged if the Tribunal inquires into the treatment that will be provided pursuant to any Order that is made. Furthermore, if upon inquiring into that treatment the Tribunal has questions – or possibly in some cases concerns – it cannot put those questions to one side or regard them as 'out of scope', it must raise and discuss those matters with the parties.

This Charter obligation is arguably reinforced or entirely compatible with the renewed focus across the entire health system on quality and safety, arising from *Targeting zero – the report of the review of hospital safety and quality assurance in Victoria* (the Duckett review).[3] If quality and safety is to be a foundation principle in health care, doing nothing, or adopting a 'not my responsibility' response to a situation where something is unclear or does not seem right, is not an option.

2. The parameters of the Tribunal's role or interest in treatment

The Tribunal's role is distinct and defined. Most critically no one, including the Tribunal, should confuse it with directing how a person is to be treated.

This is even the case where the Tribunal makes an ECT Order. An ECT Order does not require the use of ECT, rather it authorises the use of ECT within certain parameters (in other words, a maximum number of treatments over a defined period of time). Of course ordinarily it would be anticipated that ECT will commence very soon after an Order is made. But how many of the authorised treatments are administered, and at what frequency within the authorised duration of the Order, are day-by-day clinical treatment decisions made by the treating team in collaboration with the individual patient, their carer/s and subject to ongoing reassessments of capacity.

So given the Tribunal's role is not to direct treatment (that is, we are not there to say 'this is what we would do / you should do') how is its interest in treatment to be defined? The answer to this question needs to reflect not only the Tribunal's duties, functions and powers under the Act but also certain practical realities. Most critical of these are that its involvement or intervention in relation to each individual is relatively brief, and furthermore we do not have ongoing responsibility for a person's treatment and support. In this legal and practical context the most accurate and appropriate description of the Tribunal's role is that of constructive inquiry, clarification and reflection.

Constructive inquiry and clarification involves:

- confirming the full scope of treatment and support that is being offered to a person – both the compulsory elements, and those (such as establishing links with Mental Health Community Support Services) that are available to a patient should they chose to accept them
- understanding the rationale underpinning a particular treatment plan
- exploring gaps – these could be actual gaps in treatment, or gaps in the information provided to the Tribunal, and may be identified based on the views and preferences of the patient, or the Tribunal's own concerns (such as clarifying the availability of support with accommodation issues, access to psychological interventions, responses to trauma)
- ensuring there is at least the beginning of a collaborative pathway that may lead to the revocation of an Order, which in some cases may simply be identifying very early 'next steps'.

The most effective Tribunal hearings are those where there can be a constructive discussion about these matters, the most difficult and sometimes tense hearings are those where the description of treatment is limited to 'medication and psycho-education', and the pathway to Order revocation amounts to little more than 'the patient does as we direct'.

Now across several thousand hearings each year there is a broad spectrum. Often these matters will be very clear and the discussion is positive and future-focused. But there remains a sizeable proportion of hearings where these matters are opaque and need to be the subject of closer scrutiny. This can cause discomfort, but it is simply not open to the Tribunal to ignore these matters; they must be explored and clarified.

3. (Re)framing Issues relating to treatment in order to avoid confusion

In discussions to date about the Tribunal's role in relation to treatment the focus has tended to be on confirming what its role isn't, which means there remains some uncertainty about what its role is. This is an area that is never going to be amenable to definitive statements, but one way to promote clarity is to examine the issues that most frequently give rise to confusion and explore how they might be approached in the context of constructive inquiry and clarification.

3.1 Type of medication and / or how it is administered

Traditional approach: the Tribunal doesn't decide what medication a person is to be given and whether it's administered as a tablet or injection.

Actual relevance to the Tribunal's role:

- The principles of the Act promote recovery-oriented practice which recognise the patient as the expert regarding their own treatment – overriding their preference for a particular medication is a significant departure from this.

- If a person is willing to accept a particular medication, or oral medication over a depot, is an Order required or could treatment be voluntary?

Constructive inquiry: explore both the patient's preferences and the treating team's reasons for thinking those preferences cannot be respected.

3.2 Dosage levels

Traditional approach: the Tribunal doesn't decide the dosage levels of medication.

Relevance to the Tribunal's role: given the definition of treatment in the Act, and the principles promoting recovery-oriented practice, optimal outcomes and full participation all require consideration of side-effects of treatment and a person's subjective assessment of the benefits / costs / impact of treatment.

Constructive inquiry: explore the patient's concerns about dosage levels and the impact they experience of a particular dose, confirm there has been an opportunity to raise these concerns with the treating team and explore the treating team's response.

3.3 Actual or potential gaps / deficiencies in a treatment plan

Relevance to the Tribunal's role:

- Can the Tribunal be satisfied treatment will be provided if an Order is made?
- Is there a reasonable basis for anything beyond an Order of short duration?
- Are the principles of the Act being properly considered?

Incorrect approach:

- Purporting to direct changes to a treatment plan.
- Failure to explore potentially multiple causes and contributing factors.

Constructive inquiry and clarification:

- Asking for further explanation as to what is or is not included in a treatment plan.
- Confirming the scope of future options and issues for further discussion between the patient the service, and any relevant third parties.
- Clarifying the extent to which the issue is relevant to the decision that needs to be made by the Tribunal and whether or not the Tribunal has an ongoing interest in the issue.

3.4 Case study – 'Sam'

Background

- Young man who grew up in very disadvantaged circumstances with a history of trauma.
- Parents now deceased, limited contact with siblings.
- Diagnosis of schizophrenia and history of chronic drug use.
- At times of relapse engages in criminal behaviour – stealing and sexual offences (arguably 'low-level' but undoubtedly traumatic for those affected).
- Extremely vulnerable, limited ability to care for himself, isolated, high risk of homelessness, possible acquired brain injury (ABI).

Hearing 1

- After several months in an inpatient unit Sam was transferred to a Secure Extended Care Unit (SECU).
- At the time of this hearing Sam had been in SECU for six months, his symptoms were reported to be well managed and his mental state stable.
- Sam had not left SECU for five months – two reasons were put forward:
    - to prevent access to drugs
    - Sam did not yet have a discharge destination.
- The treating team was seeking a further six-month Inpatient Treatment Order.

The issues of concern from the Tribunal's perspective were as follows.

- During his six months in SECU Sam had not been assessed for an ABI.
- Given Sam's symptoms were well managed was the purpose of his ongoing detention primarily to manage drug use? If so this is problematic – it cannot be the primary purpose of an Inpatient Treatment Order and SECU placement. Given Sam was being open about the likelihood of continuing to use drugs the situation risked becoming one of indefinite detention.
- Five months without stepping foot outside SECU constitutes an extraordinarily restrictive approach to treatment. Furthermore, the lack of a discharge destination provides no rational basis for restricting leave.

Outcome of Hearing 1

The Tribunal made an eight-week Inpatient Treatment Order with clear directions that at the next hearing:

- a revised treatment plan would be required, developed in collaboration with Sam and his legal representative
- the Tribunal was explicit that the revised treatment plan needed to include a clear strategy for Sam's transition from SECU and

- Sam's treating psychiatrist from his referring service would be required to participate in the next hearing to enable meaningful discussion about progressing towards discharge from SECU.

Hearing 2

There wasn't another hearing in eight weeks because Sam was not only discharged from SECU, he left as a voluntary patient. The next hearing was in six months – triggered by Sam being placed on an Inpatient Temporary Treatment Order following a relapse and reported non-adherence. At this hearing Sam and his lawyer advised the support provided to Sam in the period following his SECU discharge was limited to four home visits to administer depot.

Issues from the Tribunal's perspective were as set out below.

- What is happening in Sam's case simply doesn't make sense. While the reduction in the level of restriction for Sam is positive how can the gains associated with his extended inpatient and SECU stay be maintained and progressed in the absence of an intensive support plan in the community (regardless of whether that support is provided compulsorily or on a voluntary basis)?

- Sam's discharge destination meant he did not return to his referring service. Rather, his community treatment was provided by a third service – it was impossible to gauge whether the three services (original referring service, SECU, new community team) had been involved in ensuring a comprehensive treatment plan was developed that was informed by a longitudinal understanding of Sam's needs and circumstances.

- It appeared referrals and linkages to broader supports had not occurred and there were no plans as to how to address Sam's long-term needs.

The Tribunal made an eight-week Order, acknowledging that Sam's circumstances were extremely complex and there was no quick or easy fix, but in the absence of a treatment plan that at least mapped a pathway for working on these issues, there was no reasonable basis (despite the treatment criteria all being satisfied) for making anything other than a relatively short Order.

4. The Tribunal's engagement with treatment issues must be solution-focused

Just as important as being clear about why the Tribunal has an interest in treatment, and the scope or nature of that interest, is *how* the Tribunal approaches this aspect of its role. This brings us to the Tribunal's solution-focused framework which guides its approach to hearings.

Critically, a solution-focused approach is not about miscasting the Tribunal as a source of solutions, and an important dimension of this distinction is that a solution-focused approach does not confuse the role of the Tribunal with the role of the treating team. Rather, a solution-focused approach recognises that a hearing can be conducted in a manner that facilitates participants (patients, carers and clinicians) discussing, identifying and committing to future actions.

So what are the characteristics of a solution-focused approach to the exploration of treatment issues in a hearing?

4.1 Exploratory rather than directive

This has been addressed above.

4.2 Constructive and respectful questions and discussion

Going back to the case study of Sam this would be characterised by prompts and questions such as:

- Can you tell us what is planned to assess Sam's possible ABI and any other disability? (In contrast to a question such as *why haven't you…?*)
- Who was involved in developing Sam's post-SECU treatment plan and what did it include? (In contrast to an assessment or judgment such as *it seems little was done to assist Sam back in the community*.)
- Sam's needs appear very complex – what are the plans for involving broader support services or possibly exploring additional funding sources?

More broadly, and looking forward to what we might do in the future, the Tribunal needs to look at ways in which we might enhance our approach to these issues, possibly through tailored protocols and practices that identify complex treatment issues in advance in order to enable the most effective exploration of these issues in hearings with few surprises. One example of where we have done this already is the development of a tailored reporting template for hearings concerning SECU patients.

4.3 Informed by the preferences and views of patients, nominated persons and carers

The extent to which an issue is raised or explored by the Tribunal must take into account the views and preferences of the patient (including those expressed in an advance statement or conveyed by a nominated person), but they are not definitive. If the Tribunal has questions, generally it needs to ask them. If the subsequent discussion indicates a patient is happy with or not concerned about a particular matter, careful consideration needs to be given to pursuing it further. But the Tribunal must be attuned to the reality of power imbalances and that an individual's ability to self-advocate may be limited.

4.4 Informed but not defined by the reality of available services

We all know the mental health service system operates under significant capacity and resourcing constraints, and some of its critical intersections are with equally stretched sectors / services – especially housing. The discussion of treatment issues in a Tribunal hearing cannot imagine a perfect world, but equally it must not shut down as soon as 'resource constraints' are cited in response to questions. A formulaic approach to these complex issues or tensions is not appropriate, but a useful navigation principle is to endeavour to distinguish between individual and systemic issues.

The Tribunal cannot ignore systemic issues which are a legitimate topic of inquiry, but a tailored approach is needed. An example that arises not infrequently in Tribunal hearings is where a person's progress appears to be being thwarted by different parts of the mental health system not intersecting smoothly and effectively:

> Service 1 advises the next step for patient A is to transfer / transition to service 2, service 2 says no they can't, as a consequence patient A remains in limbo. Service 2 may cite a range of reasons – geography and admission criteria being the most frequent in the Tribunal's experience.

These scenarios must be thoroughly scrutinised and if they are in fact an instance of the system's inability to respond to complex needs, or perhaps an instance of rigid inflexibility, the Tribunal cannot just look away. In response to such matters the Tribunal has previously employed a range of measures (often with significant enthusiasm on the part of treating teams) including joining as parties all services that have a role to play in progressing an individual's treatment, and requiring their involvement in special-fixture hearings to explore these issues in detail. The focus of such hearings is not to criticise or berate but rather provide a forum for discussion, and exploration of options for progress; but there is also a place for requiring accountability. The Tribunal can also play a role linking patients in a scenario such as this with advocacy and legal services. In some instances the Tribunal will also formally raise such cases with the Office of the Chief Psychiatrist.

4.5 Agility and containment

No matter how well-planned and adherent to a solution-focused approach the raising of an issue may be, responses and discussion can play out in an unexpected or undesirable manner. In the event this happens the Tribunal should close or redirect the discussion and do what is possible to reduce distress or tension. At the same time solution-focused discussions can legitimately and constructively involve disagreement and we should not be hesitant to provide space for this to occur. Research repeatedly confirms participants in any legal process will judge the legitimacy of outcomes more on the basis of whether they feel heard and respected, than simply on the basis that they feel they have 'won'.

Following on from this it is important to emphasise a solution-focused approach does not detract from the need for rigour. Solution-focused discussions may at times be difficult or uncomfortable. If that discomfort arises because of the Tribunal's approach, we have fallen short. If the cause of discomfort is that reasonable questions were unable to be answered, or a view that 'the Tribunal had no right to ask' that is entirely different.

5. Conclusion

It is unambiguous that the Tribunal has a role in relation to treatment and hearings must explore treatment issues. Where there is a shared understanding of this, and a coherent framework to guide the process by which it occurs, hearings should no longer be regarded simply as an unavoidable consequence of placing a person on a compulsory Treatment Order. Instead, hearings can and should be an opportunity for valuable dialogue with and between patients, carers and treating teams in which

constructive inquiry about, clarification of, and reflection on treatment can make a positive contribution to a person's progress towards recovery.

[1] This is adapted from the Monash Health – Mental Health Program Professorial Lecture delivered by Matthew Carroll on 19 June 2017.

[2] Relevant information includes an explanation of the advantages and disadvantages of treatment and an explanation of any beneficial alternative treatments (see section 69(2)).

[3] Department of Health and Human Services 2016, *Targeting Zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care, Report of the Review of Hospital Safety and Quality Assurance in Victoria*, led by Dr Stephen Duckett, State Government of Victoria, Melbourne.