



Royal Commission into Victoria's Mental Health System

**Further submission from the
Victorian Mental Health Tribunal**

August 2020

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LIST OF ABBREVIATIONS USED IN THIS SUBMISSION	
Act	<i>Mental Health Act 2014 (Vic)</i>
Board	Mental Health Review Board
Charter	<i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>
Commission	Royal Commission into Victoria's Mental Health System
CTO	Community Treatment Order
ITO	Inpatient Treatment Order
NDIS	National Disability Insurance Scheme
OCP	Office of the Chief Psychiatrist
SECU	Secure Extended Care Unit
SoR	Statement of Reasons
Tribunal	Mental Health Tribunal

A NOTE REGARDING LANGUAGE

In this submission references to the provisions of the Act or the Tribunal's statutory functions will use the terms patient/s and carer/s as these are the terms used in the Act. Elsewhere, for instance when referring to broader activities or initiatives undertaken by the Tribunal, the terms consumer/s, family and support person/s may be used

CASE STUDIES

The case studies used in this submission are based on hearings conducted by the Tribunal. All case studies have been de-identified including making some changes that do not impact on the issues under consideration or the Tribunal's decision and reasoning.

FOOTNOTES

Unless otherwise specified all references to statutory provisions are to provisions of the *Mental Health Act 2014 (Vic)*.

EXECUTIVE SUMMARY

Victoria's uniquely high rate of use of compulsory Treatment Orders is a product of many factors. The Mental Health Tribunal (Tribunal) does not have a complete explanation for the cause of this. We have previously highlighted that in our view the use of Treatment Orders as a tool for determining access to services, and an approach to issues of risk that is highly risk averse and illogical are both significant factors. In addition, constant changes to a person's treating team mean their engagement with services is often transactional rather than relational, and the resultant lack of longitudinal relationships gives rise to a void that is frequently filled by coercive treatment.

Critically, and as the Commission's Interim Report recognises, many factors contribute to poor mental health. Based on our direct observations the Tribunal would emphasise that causes of the complexity, and at times personal chaos, that can be a contributing factor to the use of coercive interventions, are multifactorial and as such solutions will not be found exclusively within the domain of mental health services.

We welcome the Commission's examination of our functions and approach as part of its inquiries related to compulsory treatment, and have appreciated the opportunity to engage with the Commission about what might be done to reduce the rate of compulsory treatment in the future. In developing these proposals, none of which purport to be a quick or complete solution, we have looked at but also beyond the Tribunal's functions. We have also used the reasonable limitations framework in section 7(2) of the *Charter of Human Rights and Responsibilities Act 2006* (Charter) as a point of reference, or lens, through which to develop these proposals. This aspect of the Charter reminds us to focus on the fact that compulsory treatment is a limitation on an individual's human rights. This is not intended to demonise psychiatric interventions, and it has been recognised that compulsory treatment is compatible with the Charter. What it does is require a focus on the core dilemma of compulsory treatment, it also provides a framework for determining where the balance lies when seeking to resolve that dilemma in individual circumstances.

In summary, the Tribunal believes the following proposals can contribute to a reduction in compulsory treatment:

1. The *Mental Health Act 2014* (Act) authorises individuals to exercise the coercive authority of the state, where such authority is being exercised it should be in accordance with clearly defined, universal best practice. The Victorian Collaborative Centre for Mental Health and Wellbeing should work with consumers, carers and clinicians to distil best practice in the use of compulsory treatment – when it should be considered and used, alternatives, and how it can be minimised (in terms of both use and duration). Training in best practice should be required for all people exercising authority under the Act.
2. The mental health principles enshrined in the Act should be strengthened:
 - The Act should include a principle of equivalence – i.e. access to services should be the same regardless of whether a person is a voluntary or compulsory patient.
 - The objective of supported decision making should be accorded greater prominence.
 - Voluntary assessment and treatment, and respect for a person's views and preferences should be assumed and only displaced where not possible.
 - An explicit obligation attached to the use of compulsory interventions should be to take all reasonable steps to maximise and restore a person's rights, dignity and autonomy at the earliest opportunity.
3. The Act should set down a framework to guide the consideration and application of the principle of dignity of risk in individual circumstances. The framework must recognise setbacks have a place in individual recovery, and that coercive responses to risk are neither guaranteed, nor without risks of their own. The framework should facilitate an approach to risk that is balanced, rigorous and less risk averse. Just as importantly, the framework must provide reassurance to clinical and other decision makers that when, after proper consideration of all relevant factors they adopt a less risk averse approach, should there be a later setback they will not be blamed / criticised.

4. When determining the duration of a Treatment Order the Tribunal should be required to consider the treatment plan that will be implemented pursuant to the Order. While not a treatment decision maker the Tribunal should assess the treatment plan against defined standards or criteria including participation of the consumer and their support people; the inclusion of supports and interventions beyond psychotropic medication; coordinated / 'joined-up' provision of supports; and the articulation of a pathway to less restrictive treatment.
5. The Act should establish a complex matters list within the Tribunal to enable intensive case-management of hearings for relevant matters, including through the conduct of pre-hearing conferences. The Act should specify a non-exhaustive list of indicators to guide the Tribunal's identification of cases to be allocated to the complex matters list. Where appropriate the Tribunal should be empowered to refer complex matters to the Office of the Chief Psychiatrist and/or the Mental Health Complaints Commissioner.
6. Access to legal representation and alternate forms of rights-based advocacy for consumers who have a Tribunal hearing should be increased. To maximise the potential for beneficial outcomes and to promote supported decision making, holistic, longitudinal representation or advocacy services based on the model employed in health-justice partnerships should be available to consumers who require and want this type of support.
7. Mental health services should be resourced, and then obliged to ensure that the treating team representatives who participate in Tribunal hearings know the patient and have the authority to fully engage in solution-focused hearings, including committing to next steps.

Part 1. Introduction

The second phase of the Commission's inquiry has included a significant focus on compulsory treatment under the *Mental Health Act 2014* (the Act). The Tribunal has appreciated the opportunity to engage with the Commission about this issue, including the provision of a witness statement and participation in an expert panel by the Tribunal's President; and two roundtable discussions involving the Commission and Tribunal representatives.

This further submission is in response to matters arising in the roundtables. We have reflected on those discussions and further developed proposals for what might be done to help reduce rates of compulsory treatment in the future. There were also a small number of issues that were to be discussed in the roundtables but were unable to be addressed or only covered summarily due to time constraints. These matters largely concerned the operation of the Tribunal and are covered in Part 4.

1.1 Compulsory treatment in Victoria

Victoria's uniquely high rate of use of compulsory Treatment Orders is a product of many factors. The Tribunal does not have a complete explanation for the cause of this. In summary we have previously highlighted:

- The use of Treatment Orders as a tool for determining access to services in an environment where demand significantly exceeds capacity.
- An approach to issues of risk that is highly risk averse and illogical – there is a hesitance to intervene when a mental health crisis is emerging, and a reluctance to 'wind-back' when a person has recovered.
- Constant changes to a person's treating team mean their engagement with services is often transactional rather than relational, and the resultant lack of longitudinal relationships gives rise to a void that is frequently filled by coercive treatment.

The Tribunal has also acknowledged that as the entity making Treatment Orders it bears part of the responsibility for the high rates of compulsory treatment. We welcome the Commission's examination of our functions and approach. At the same time (and this is not intended to deflect scrutiny) we would offer the observation that to an extent compulsory treatment can be 'self-sustaining'. The Tribunal must scrutinise every Treatment Order against the treatment criteria, taking into account the mental health principles set down in the Act, and revoke Orders where the criteria are not met. However, once compulsory treatment is initiated, and for the longer it remains in place, less restrictive, voluntary alternatives can become more elusive. For this reason, while some of the proposals in this submission relate to the Tribunal and its functions, they also look further afield.

While not wanting to over-simplify this diabolically complex issue, the Tribunal notes the Commission's interim and final recommendations will redesign Victoria's mental health system so that it meets the needs and expectations of consumers, they will also address its acknowledged under-resourcing. An alignment between needs, expectations and what is available, and enhancing the system's capacity to deliver, is potentially going to be the single most effective driver of a reduction in compulsory treatment. At the same time, and as the Commission's Interim Report recognises, many factors contribute to poor mental health. Based on our direct observations the Tribunal would emphasise that causes of the complexity, and at times personal chaos, that can be a contributing factor to the use of coercive interventions, are multifactorial, and as such solutions will not be found exclusively within the domain of mental health services.

1.2 This submission

To develop these proposals the Tribunal has drawn heavily on the *Charter of Human Rights and Responsibilities Act 2006* (the Charter) and in particular the reasonable limitations framework set down in section 7(2). Examining compulsory treatment through the lens of this framework we have identified the following proposals:

- State-wide training in best practice in relation to the use of compulsory treatment.
- Strengthening the mental health principles in the Act.
- Expanding the provisions in the Act related to dignity of risk.
- Defining a role for the Tribunal in relation to treatment planning.
- Procedural powers to enable the Tribunal to more effectively case manage complex matters.

Part 2. Reasonable limitations on human rights – section 7(2) of the Charter

Section 7(2) of the Charter defines when human rights protected under the Charter can be limited:

(2) A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—

- (a) the nature of the right; and
- (b) the importance of the purpose of the limitation; and
- (c) the nature and extent of the limitation; and
- (d) the relationship between the limitation and its purpose; and
- (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

It has been confirmed that the involuntary treatment framework contained in the former *Mental Health Act 1986* (former Act), and by extension the compulsory treatment provisions of the current Act, engage and limit a number of rights protected under the Charter, but the framework does satisfy a reasonable limitations analysis conducted in accordance with section 7(2) of the Charter.

In *Kracke v Mental Health Review Board & Ors* Bell J stated¹:

The limitations on Mr Kracke's human rights imposed by the operation of the provisions of the Mental Health Act for making, maintaining and reviewing involuntary and community treatment orders are made under law, reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom. Therefore the provisions satisfy the general limitations provision in s 7(2) of the Charter. Unreviewed orders are not incompatible with human rights because the system contains a range of safeguards and checks and balances of which reviews, although of considerable importance, are only one part. Thus the proportionality of the limitations in treatment orders does not depend on board review alone.'

Bell J confirmed this in *Kracke v Mental Health Review Board & Anor (No 2)*²:

*In conducting a review of a decision of the Mental Health Review Board, the tribunal is a public authority bound by the Charter of Human Rights and Responsibilities Act 2006. The critical issues in the present case are engagement and justification. Mr Kracke's human rights are clearly engaged in several respects by the decision under review, and would be engaged in the same way by any confirmation of that decision by us. We particularly refer to the right to freedom from medical treatment without full, free and informed consent, to freedom of movement and to privacy, all of which were specified in *Kracke v Mental Health Review Board*. However, the involuntary treatment is being given under law (the Mental Health Act) and has been demonstrably shown to be medically necessary and proportionate to Mr Kracke's medical needs. There are adequate safeguards to protect his human rights in terms of future treatment. Therefore, according to the provisions of s 7(2) of the Charter, the treatment is justified in his individual circumstances. Continuation of the treatment is compatible with his human rights.*

Confirmation that a framework for compulsory treatment can be compatible with the Charter does not mean it is a matter of 'case closed'. The Tribunal's view is that the Charter and its reasonable limitations framework challenges us to reorient how we think about compulsory treatment. A key feature of section 7(2) of the Charter is that it focuses analysis and scrutiny on actual or proposed limitations on human rights, which can be quite different to the scrutiny that occurs pursuant to the Act.

Arguably, because the objective of using compulsory treatment to promote recovery from mental illness has been recognised as a legitimate purpose, what might be described as a blind spot has developed. That compulsory treatment is a profound limitation on human rights might be acknowledged, but because it's for a legitimate purpose, that difficult reality is often not engaged with to a sufficient extent. What the Tribunal often observes is that the legitimacy of the limitation on human rights (i.e. the detention, and/or supervision and/or compulsory medication that occurs pursuant to Orders) is not questioned or scrutinised to the same extent as the person seeking greater autonomy, and how they would choose to exercise their autonomy.

¹ *Kracke v Mental Health Review Board & Ors* (General) [2009] VCAT 646 (revised 21 May 2009), [784].

² *Kracke v Mental Health Review Board & Anor (No 2)* (General) [2009] VCAT 1548, [15].

To be clear this is not a binary scenario. Good decision making under the Act must endeavour to understand the person who is being treated – who they are, what preceded their current situation, their future goals and the decisions they want to make. But a human rights-based approach must of necessity involve scrutiny of treatment – how is it helping, what are its negative effects, and if it is not what the person wants how that might change immediately or over time (and to be clear this is not about simply requiring or expecting the person to change their views and preferences).

Remaining alert to, acknowledging and exploring the fact that compulsory treatment is a limitation on a person's human rights does not marginalise or demonise psychiatric treatment, rather it focuses analysis and scrutiny on what is the core dilemma of compulsory treatment. Doctors and clinicians draw on extensive training, experience, clinical expertise and care for their patients to identify a range of supports and interventions intended to promote recovery. Consumers have the unique expertise of knowledge of their own experience, what they want for their own life and what they think will be of assistance. Where the two don't match, the consequences need to be understood by reference to a broad concept of restriction / least restriction, and a recognition that each retreat from the person's preferred approach adds to a cumulative limitation on their human rights (both objectively and subjectively) and this needs to inform scrutiny to assess where the appropriate balance lies.

Part 3. Proposals / recommendations

3.1 State-wide training in best practice use of compulsory treatment

Given the compulsory treatment framework in the Act authorises profound limitations on the human rights of individuals, it is unusual that there are no mandatory or consistent requirements for people to be trained before exercising power under the Act. This is not to diminish the professional qualifications, skills and training that relevant individuals have in medicine, nursing and allied health, but an acknowledgement that these disciplines do not typically train individuals in what are not only clinical matters, but actions that involve exercising the coercive authority of the state.

From what the Tribunal observes, what training and education there is around compulsory treatment focuses on ensuring adherence to the procedural steps that need to be followed when making or applying for Orders. While this is important, of itself it is not enough. Knowing what forms to complete and the relevant treatment criteria specified in the Act does not engage with the fundamental questions of when compulsory treatment should be considered and used, and if used, how it can and must be minimised. In the absence of a broad and consistent approach, training is also locally driven and thus reflective of prevailing local cultures which can be problematic. Approaches to the use of coercion should not be driven by catchment boundaries but consistent with what is regarded as universal best practice.

To be clear the Tribunal is not proposing training with a dry or abstract focus on either the Act or the Charter. On the contrary, while both need to be fundamental considerations and woven into the content of training, the focus should be on what has been distilled or identified as best practice concerning the use of compulsory treatment. Distilling or defining best practice for the purposes of such training needs to involve consumers, carers and clinicians, for this reason, and given its intended functions as articulated in the Commission's interim report, the Victorian Collaborative Centre for Mental Health and Wellbeing could be ideally placed to develop both a best practice framework and associated training. This training – in whole or in part – should be required for all people exercising authority under the Act.

Regarding where the Tribunal 'fits' in relation to this we would envisage at least two dimensions:

- Tribunal decision making needs to be informed by what is understood to constitute best practice in relation to compulsory treatment, accordingly, this would need to form part of the induction and professional development of Tribunal members and relevant staff.
- Currently, the Tribunal delivers training to mental health services on how to prepare for and participate in Tribunal hearings so as to promote the objective of those hearings being solution-focused. We would continue to deliver this training – either independently, or as part of a broader program.

In putting forward a proposal that asks consumers to be part of an initiative to define best practice in relation to compulsory treatment, the Tribunal acknowledges that for many consumers best practice is for there to be no compulsory treatment. We respect and do not dismiss that view. However, there can and needs to be a collaborative discussion to identify what might be regarded as the in-between (and potentially transitional) space between where we are presently (over-use) and a longer-term objective (minimal or no use).

3.2 Strengthen the mental health principles in the Act

The Tribunal's original submission acknowledged the impact of the Act has fallen short of expectations. At the same time it has had some impact, and from the Tribunal's perspective the mental health principles set down in section 11 of the Act do play an important role in capturing and conveying community expectations regarding the support that should be available for people experiencing mental illness, and those who care for them. The Tribunal has used the principles as a point of reference, not only in relation to interpreting and applying the Act, but also in our broader activities. The Tribunal's vision is that the mental health principles are reflected in the experience of consumers and carers, and each year our annual report summarises the initiatives we have undertaken to seek to embody and promote the principles.

While amending or strengthening the mental health principles is not a magic bullet, it can influence the design and delivery of mental health services and how issues and dilemmas are framed, analysed and responded to. In this context the mental health principles can do more to embed a human rights approach to the delivery of services, including the use of compulsory treatment.

It is important to recognise that while the principles reside in legislation that is most commonly associated with compulsory treatment and restrictive interventions, they are predominantly universal – i.e. they articulate standards that are relevant regardless of whether a person is accessing treatment voluntarily, or being treated under a compulsory Order. In that context, and to help remedy a distortion described in the Tribunal's first submission, the principles would be enhanced by the addition of a principle of equivalence. A principle of equivalence should confirm or guarantee that a person's access to treatment (whether that be the range of treatments, intensity of supports, and/or timeliness of interventions) should be the same regardless of their legal status.

Given the centrality of supported decision making to understanding what the principle of least-restriction 'looks-like' in individual situations; the realisation of the full suite of mental health principles; and adhering to both the Charter and the *Convention on the Rights of Persons with Disabilities 2006*, it should be afforded greater prominence. The current section 10(d) could be reframed as a mental health principle and an obligation to promote supported decision making.

Certain principles are particularly relevant in the context of compulsory treatment. These could be strengthened to better integrate section 7(2) of the Charter (self-evidently the following proposals do not purport to be in statutory form):

(a) persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred

Voluntary assessment and treatment should be assumed and only displaced where it is not possible.

(c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected

Where possible people must be involved in decision making, the starting assumption should also be that their views and preferences must be respected except where this isn't possible.

(d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk

This is addressed in detail in 3.3 below.

(e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;

Any limits on rights, dignity and autonomy must be minimised in terms of both the nature of the limit and its duration; an obligation attached to compulsory treatment should be to take all reasonable steps to maximise and restore a person's rights, dignity and autonomy at the earliest opportunity.

3.3 Dignity of risk

Section 11(1)(d) of the Act enshrines the dignity of risk principle, a concept that in the Tribunal's opinion is critical to reducing the rate of compulsory treatment. The Tribunal's original submission described the pervasive focus on risk and risk aversion that is a feature of the delivery of mental health services. It also described an illogical response to risk that means individuals have greater autonomy to make potentially harmful decisions at a time when their judgment is most compromised, but their autonomy is restricted when the potential for harm is reduced. Importantly, it also acknowledged that our community sends clinicians totally contradictory messages. On the one hand they are told 'be less risk averse'. On the other, when they are, and should something later go wrong, they are immediately blamed and asked, 'why didn't you stop

this happening?'. In short there is still a long way to go in developing our understanding of what this principle means and how to engage with it in practice.

It is instructive to compare the Act's approach to dignity of risk and how it addresses capacity. Both dignity of risk and capacity can be 'flashpoints' for oppositional and stalled discussions. There are parallels between the polarities of "I have capacity to make this decision / I say you don't have capacity" and "I want to take this risk / I say the risk is too great". An important difference is that whereas the Act enshrines the dignity of risk principle but provides nothing further, in relation to capacity it provides a framework that can be used to advance discussions and the exploration of different perspectives. Specifically, the Act:

- Sets down a rebuttable presumption of capacity (section 70(2)).
- Articulates guiding principles each of which convey a critical message regarding community expectations concerning the assessment of capacity (section 68(2)).
- Defines four domains of capacity that help bring rigour and specificity to capacity assessments (section 68(1)).

A similar approach could be employed in relation to dignity of risk in order to foster better understanding of the principle and meaningful exploration of what it means in individual situations. Guiding principles and considerations relevant to delineating between reasonable and unreasonable risks could include (again these are not in statutory form):

- Recognising that setbacks can be educative and have a legitimate place in recovery.
- An essential parallel to the preceding point is to recognise that setbacks do not mean earlier, non-coercive decisions or responses to risk were wrong, provided those decisions were made after careful consideration of all relevant factors.
- Guidance on how to scrutinise risks thoroughly, in particular the need for clarity and specificity about the grounds for concern, the nature of the risk, who it affects, and potential short and long term consequences, including on a person's future participation in community life.³
- Emphasising the need to identify and consider protective factors and mitigations other than compulsory treatment.
- Acknowledging that coercive responses to risk are not risk free and in fact carry risks of their own; and furthermore, they are not guaranteed to work – mental health relapses can and do occur even when people are receiving treatment, including compulsory treatment.

By fostering genuine traction for the principle of dignity of risk, rigorous consideration of the types of matters referred to above will also enhance a reasonable limitations assessment of any proposed restrictions on an individual's human rights.

3.4 Treatment planning and the role of the Tribunal

Given the Tribunal periodically examines the circumstances of every person receiving compulsory treatment in order to determine whether a further Treatment Order should be made, not only are we ideally placed to examine treatment, we must do so, as proper consideration of the criteria for Orders is not an exercise in abstraction. However, articulating the Tribunal's role in relation to treatment and the parameters of that role is complicated, and previous statutory attempts to define a role for the former Mental Health Review Board (Board) largely failed to achieve anything meaningful.

Key to the complexity is that the Tribunal is not and should not be a treatment decision maker, determining such things as medication, dosage, mode of administration etc. Sections 19A and 35A were inserted into the former Act in 2003 and sought to navigate this complexity by vesting the Board with a procedural mandate in relation to treatment planning – i.e. the Board confirmed a particular process had been followed in the development of an involuntary patient's treatment plan. This framework added little of value to treatment planning. Documents were generated that seemed primarily if not exclusively intended for the Board, rather than being a record of organic and ongoing discussions and negotiations about the treatments and supports a person would be

³ Section 11(1)(b).

afforded, and options or strategies for less restrictive treatment. A significant proportion of these plans simply identified the parties to the plan, summarised treatment solely in terms of medication and appointments, and specified a person could be returned to hospital if they did not comply. Despite the clear deficits these plans satisfied the legislative scheme.

The Tribunal's view is that its interest or role in relation to treatment can be meaningfully and appropriately defined by linking it to our role in determining the duration of Treatment Orders (up to the specified statutory maximum). Presently the Act is silent on what the Tribunal should consider when determining the duration of Orders. The Act should specify that when determining Order duration one thing the Tribunal must consider is the treatment plan that is to be implemented pursuant to the proposed Order. This is inherently logical in that (to state the obvious) it is the treatment and support facilitated by a Treatment Order, and not the Order itself, that supports a person and contributes to recovery. As such the duration of the Order should reflect what is proposed to be done pursuant to it.

To an extent this would reflect the Tribunal's current approach to determining the duration of Orders but there is merit in this being specified in the Act. It would contribute to consistency and clarify for both consumers and treating teams the significance and relevance of treatment planning. It would also confirm the Tribunal's legitimate interest in these matters. It continues to be the case that when the Tribunal seeks to explore treatment planning it is regarded as venturing beyond its role, the Act should address this misconception. In doing so the Act could also identify some of the matters in relation to treatment planning the Tribunal should examine. These could be informed by the reasonable limitations framework in the Charter and community expectations regarding robust treatment planning e.g.:

- Maximal participation of the consumer and their support people (how this is framed would need to accommodate variation in individual situations – for instance some people choose not to participate; participation in the initial period of a person's first contact with mental health services would be different to six months later).
- Exploration of psychological interventions and psycho-social supports as well as psychotropic medications.
- Coordinated or 'joined-up' provision of services and supports (both within the mental health system and across different sectors / service providers).
- Identification of the consumer's specific preferences that the plan proposes to override with an explanation of why each is necessary.
- Collaborative pathway to less restrictive treatment – both interim, i.e. meeting more of the consumer's preferences, and ultimately voluntary treatment.

Should a treatment plan fall short of the standards specified in the Act a Treatment Order should only be made for a relatively short period of time. Whether by way of application or some other process the matter would come back to the Tribunal for reconsideration in light of a revised treatment plan.

3.5 Case management of complex matters by the Tribunal

Under the Act every hearing conducted by the Tribunal is *de novo*, and the same procedures apply regardless of whether there may be features of a matter that require a more intensive approach. The Tribunal seeks to address this by informal case management of matters that have been identified as complex cases. The Tribunal has developed detailed internal procedures for handling these matters, the informality refers to the absence of any procedural provisions in the Act that define what the Tribunal is able to do, and an obligation on parties to engage or participate.

At the heart of our case management processes is the objective of seeking to explore issues of concern in greater depth in order to clarify matters and promote progress to less restrictive treatment. In this context the relevant restriction/s are often (but not always) more about the setting in which a person is receiving treatment than a person's compulsory status. Essential to this is seeking to ensure that at upcoming hearings all relevant individuals and entities are in attendance, (this will often extend beyond the automatic parties to a hearing) and there is advance notice of the issues needing to be discussed and options that need to be explored. The Tribunal's statutory leverage in these matters is somewhat blunt – the making of shorter Treatment Orders which have the effect of bringing matters back before the Tribunal to enable progress to be monitored in the context of deciding whether to make a further Order. This is often not an ideal

fit because a frequent feature of these matters – including from a consumer’s perspective – is that whether a Treatment Order should be made is not the central or indeed a contested question, but rather it is what should be happening pursuant to the Order.

Presently the Tribunal is only able to case-manage a very small number of matters. We would describe the results as mixed. In some situations case management can involve little more than bearing witness to a situation of ongoing stasis. In other matters, while case management is never the direct cause of tangible improvements in the relevant circumstances, the scrutiny and accountability that is facilitated by case management is a contributor to change. The case of ‘Sandra’ in Appendix A is a success story.

The Tribunal proposes that the Act should recognise and respond to the fact that complex matters require a different response and should position the Tribunal to facilitate a tailored approach. This could be achieved through the creation of a complex matters list. Regarding the question of what cases should be within the scope of such a list, the Tribunal’s view is that rather than being prescriptive, the Act should set down principles or considerations that the Tribunal is required to take into account when identifying matters for the list. This allows for the fact that matters which on first impression rightly raise a question, (e.g. the third consecutive application for a 12-month CTO) when examined further, are not likely to warrant or benefit from case management. The case of ‘Alan’ in Appendix A is an example of this. Possible inclusions in a list of indicators or considerations to inform the identification of complex matters include:

- The views of the patient and those who support them.
- Duration of treatment pursuant to an ITO.
- Total duration of compulsory treatment.
- Treatment history, including a person’s experience of voluntary treatment.
- Multiple agencies and services needed to facilitate less restrictive treatment.

Presently when the Tribunal identifies a case as complex, in the absence of a power to make directions, we will make a series of requests or suggestions regarding what should happen prior to, and who is to attend the next hearing. Formally, we do not have any ongoing interest in the matter until such time as there is an application for a further Treatment Order meaning there will be a hearing within a few weeks. This enlivens the Tribunal’s jurisdiction and gives us some authority to ‘check in’ on what has happened in response to the earlier requests. Sometimes what was proposed will have happened, sometimes it will not.

To address this the Tribunal proposes that for the complex matters list we should be empowered to conduct pre-hearing conferences informed or guided by ‘directions’⁴. Briefly, the process could follow a path along the following lines:

- Matter identified as complex and allocated to the complex matters list.
- If a Treatment Order is made (e.g. for six months) directions are made regarding relevant matters (e.g. exploring initiation of an NDIS application, liaison with another designated mental health service regarding transfer of care, engagement with other relevant services and support providers).
- Pre-hearing conferences at the two and four-month mark – these would not re-examine the treatment criteria, rather they would monitor progress on the earlier directions and make any amended directions that might be needed. It should be open to the Tribunal to conduct pre-hearing conferences using divisions of less than three members if that is appropriate for a matter.
- If the patient’s treating team make an application for a further Treatment Order a hearing would be conducted close to the expiry date of the six-month Order. The hearing would consider the treatment criteria taking into account matters that had been explored pursuant to the directions and pre-hearing conferences, and the evidence of individuals participating in the hearing in accordance with the directions.
- The right of the patient to apply for revocation would co-exist alongside this process.

⁴ A more suitable term might be identified, ‘directions’ has a particular meaning that is not entirely applicable in the Tribunal context.

Based on its experience with informal case management of complex cases the Tribunal proposes that it also be given a power of referral. Some matters are so intractable that any number of directions, pre-hearing conferences and hearings are unlikely to achieve a real improvement in the circumstances of the individual patient. The Tribunal should be able to refer these matters to an entity with the authority to deal with such situations, this could be the Office of the Chief Psychiatrist and/or the Mental Health Complaints Commissioner.

Part 4. The Mental Health Tribunal

4.1 Solution-focused hearings

The rationale behind the Tribunal's commitment to conduct solution-focused hearings was explained in our first submission. Briefly, it is part of our efforts to enliven the mental health principles and objectives of the Act – in particular those relating to supported decision making.⁵ To say the least there is a tension between supported decision making and the role of the Tribunal. While this cannot be entirely resolved it can be mitigated by solution-focused hearings that are designed to promote meaningful participation, and an exploration of issues that contributes to defining a pathway to less restrictive treatment. At the first roundtable the Commission expressed an interest in case studies of solution-focused hearings – a selection is provided in Appendix B.

In 2018 and 2019 the Tribunal engaged an independent consultant to undertake a survey of consumers and carers experience of hearings. The Tribunal's view is that our solution-focused approach is a key contributor to consistently positive results across a range of measures, including:

Measure (survey question)	2018	2019
Did the Tribunal explain what the hearing was about?	Yes – 90%	Yes – 91%
Did the Tribunal listen to your opinions?	Yes – 82%	Yes – 78%
Did the Tribunal treat you fairly?	Yes – 77%	Yes – 80%
Did the Tribunal explain the decision to you?	Yes – 81%	Yes – 84%
Did you agree with the hearing outcome?	Yes – 65%	Yes – 64%

Full reports for both surveys have been provided to the Commission separately.

Reports for Tribunal hearings

The Tribunal has identified that the current template for hearing reports fails to elicit the type of information needed, nor does it encourage information to be expressed in a manner that will promote solution-focused hearings. The current template was a product of its times. The information provided for Board hearings was woeful. To change practice, and to position the Tribunal to perform its function as a primary decision maker, (in contrast to the review function of the Board) it was designed to gather the more comprehensive information that was needed.

Feedback from all hearing participants has identified a range of deficits:

- It is too long for consumers to read, clinicians to write, and because there is a common tendency to confuse quantity of information with quality, in some instances reports are becoming so laden with historical detail of marginal relevance the most relevant and critical information can almost be 'hidden'.
- While reports will always need to address difficult and often contentious issues, the current template generates a focus on the negative – everything that has ever gone wrong in the past and might again go wrong in the future. A person's strengths are lost in the negative detail, it is not recovery-focused and can be bereft of hope.
- It positions the Tribunal as the primary audience which has unhelpful implications for how the information is framed and expressed.
- While this isn't attributable to the template, reports are loaded with acronyms and jargon which renders them somewhat impenetrable.

Based on review and targeted consultation the Tribunal has finalised a consultation draft for a new report template – a copy is provided at Appendix C. During September 2020 we will be undertaking much broader consultation with consumers, carers, Tribunal members, mental health

⁵ Section 10 This Act has the following objectives-

- (d) to enable and support persons who have mental illness or appear to have mental illness-
 - (i) to make, or participate in, decisions about their assessment, treatment and recovery; and
 - (ii) to exercise their rights under this Act.

Section 11(1) The following are the mental health principles-

- (c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.

services and clinicians, and advocates. We aim to introduce the new template later this year. When we introduce the new template we will also launch ‘short-sharp’ online resources to assist mental health clinicians to use the template to write succinct, recovery-oriented reports for Tribunal hearings. The key features of the new report template include that it:

- is fashioned as a letter from the treating team to the consumer that will also be provided to the Tribunal;
- seeks inclusion of the consumer’s view on the relevant matters, as well as the perspective of carers / support people;
- asks about the broader supports that are available to the consumer;
- frames the report in the context of who the consumer is and their individual goals; and
- seeks an explanation of what can be done by the treating team and the consumer to progress toward less restrictive treatment.

4.2 Representation and participation in Tribunal hearings

The Tribunal has provided the Commission with a copy of its submission to the federal Productivity Commission’s Mental Health Inquiry. In that submission we supported the recommendation that there be increased levels of legal representation for people with hearings before mental health tribunals. However, the Tribunal proposed a broader rationale centred around promoting participation, in contrast to the limited and debatable proposition that increased rates of representation lead to a different profile of hearing outcomes.

This continues to be the Tribunal’s position, but we would add to it. Firstly, broader representation than legal representation should be considered. The key consideration is what type of support would most assist the individual consumer to not only participate in a hearing, but beyond that realise their goals concerning support and treatment for their mental health. For some consumers this will undoubtedly be legal representation, for others an alternative form of rights-based advocacy will be more suited. Either should be available and able to be part of Tribunal hearings. Furthermore, representation / advocacy should, where needed and wanted, extend beyond the Tribunal hearing. Frequently, poor mental health is just one of many issues a consumer is dealing with – it often coincides with tenuous housing, disconnection from income supports, issues of interpersonal violence and other legal matters. These issues are not siloed but inter-connected, they magnify each other, and an isolated resolution of one is potentially compromised if the others are not also being addressed. The model of health-justice partnerships, with their focus on assisting a person to address issues holistically and longitudinally has potential to greatly increase beneficial outcomes, which can also represent a greater return on an increased investment in legal representation and advocacy supports for compulsory patients. Such representation / advocacy is also a very tangible means of enabling supported decision making by consumers.

Secondly, any initiatives – including increased legal representation and rights-based advocacy – to promote consumer participation in hearings can only be partially successful if the parallel issue of treating team participation is not addressed. Effective, solution-focused hearings require full participation of all parties. The issue concerning treating teams is not one of failure to attend, but rather a too frequent failure on the part of services to ensure treating team representative/s know the individual consumer, and have the authority to fully participate in solution-focused discussions, including committing to next steps. Services must be appropriately resourced, and then obliged to ensure that those attending hearings satisfy these basic requirements. If a situation is seen to warrant the making of a Treatment Order, it also warrants full participation in the process that decides whether that Order will be made.

4.3 Statements of reasons for Tribunal decisions

The Commission has asked about the possibility of the Tribunal being required to provide statements of reasons (SoRs) for every decision. Presently the Tribunal prepares an SoR upon request of either party.⁶ Requests do need to be in writing, but the Tribunal has an accessible form on its website, and if a person makes an oral request, we will assist them to put it in writing. Each year a request is made in just under 3% of hearings. Our SoR style has two objectives – meeting administrative law requirements but writing in a style that is consumer and recovery focused, and accessible to a person who does not have a legal representative. Producing this

⁶ Section 198 allows a party to a hearing to make a written request for an SoR within 20 business days of the relevant determination.

type of SoR for 3% of hearings requires one full-time legal officer, plus administrative support. Members require up to a full day to write each SoR.

The magnitude of resources needed, and work involved in finalising 8,500 SoR's per year, in contrast to 250, is difficult to imagine. Of itself this isn't necessarily reason enough to not do something, but it does mean the rationale needs to be very persuasive. Lack of access to an SoR is simply not an issue that is raised with the Tribunal. Even where people request an SoR outside the time permitted under the Act, where possible it will usually be provided.⁷ The Tribunal also notes the survey results referred to above, in which a significant majority of respondents confirmed that hearing outcomes are clearly explained orally at the conclusion of the hearing.

If the Tribunal were to provide an SoR in every case the reality is that this could only be done if SoRs were pared back to something far less comprehensive than those currently prepared on request.

4.4 The Tribunal membership

Size and structure

The Tribunal has a large, primarily sessional membership. This is a product of a range of factors:

- History – i.e. the 'inherited' structure of the Board.
- Scarcity – especially in relation to psychiatrist and registered medical members the pool of potential members is small, and individual availability usually limited, this means a large number of members is needed to cover hearing requirements.
- Business continuity – while having three-member, multi-disciplinary divisions conduct hearings is one of the Tribunal's greatest strengths and something that must be preserved, the Act does not allow for one or two member divisions to operate in an appropriately limited range of circumstances. A very large pool of members is therefore needed to ensure the Tribunal can cover all requirements, including last-minute, unforeseen gaps.

During 2018-19 the Tribunal undertook an internal review of its size and structure. The review identified a consensus view amongst members that all members should sit on hearings no less than once per fortnight, and ideally more frequently, to attain greater proficiency in their role and further enhance consistency. A finding that is arguably of even greater relevance should the Tribunal be vested with a more in-depth role in relation to treatment planning. In response the Tribunal was intending to trial alternate approaches to the rostering of members from July 2020. The trial did not proceed due to the COVID-19 pandemic.

Now further developments need to be considered. If the *Crimes (Mental Impairment and Unfitness to be Tried) Amendment Bill 2020* is passed the Tribunal will take on responsibility for forensic leave matters that are currently handled by the Forensic Leave Panel, (whose community and psychiatrist members will become Tribunal members) possibly as soon as 1 July 2021. The final recommendations of the Commission will also, potentially, have significant implications for the future structure of the Tribunal. The findings of the Tribunal's internal review continue to be an invaluable resource and position the Tribunal – and other stakeholders and decision makers – to analyse issues and identify an optimal size and structure when the scope of the Tribunal's future functions is confirmed.

Member training and professional development

Training and professional development for Tribunal members involves the following elements:

- Induction on appointment – this includes seminar-style training and the observation of hearings. New members are provided with a range of resources covering the interpretation and application of the Act; hearing procedures; ensuring procedural fairness in the specific context of Tribunal hearings; and the conduct of solution-focused hearings. Since 2019 all these resources are available to members online which facilitates ease of access in hearings, as well as ensuring the resources are constantly up to date. (Copies of these resources will be provided separately.)

⁷ Section 198(3).

- New members are allocated a mentor from their category of membership. We ask mentors and mentees to maintain contact for at least six-months and after that continuing the relationship is at their discretion.
- Based on issues being raised by divisions on a day-to-day basis or identified through other sources, the legal unit will regularly update members on emerging issues or questions concerning the interpretation and application of the Act, and/or procedural matters. This ad-hoc advice is incorporated into the online resources referred to above, so it remains accessible and up to date for members.
- Twice a year the Tribunal holds a full day members' forum. The morning is allocated to practice reflection group meetings, the afternoon is a plenary session, often the focus will be on exploring particularly complex or challenging aspects of the Tribunal's decision making. (Copies of past agendas will be provided separately.)
- The Tribunal also facilitates two twilight seminars each year. Typically, these involve a guest speaker who is a leading expert on a topic of relevance to the Tribunal. (Copies of past agendas will be provided separately.)
- Each year members in each category of membership organise a number of informal practice reflection group meetings where participants contribute case studies etc for discussion and exploration.
- In the past members never had the chance to observe a colleague in the same category of membership beyond their initial induction observation. Members are now offered the opportunity to observe hearings – one observation each year is recommended, individual members can ask to observe more hearings if they wish.
- At least once during their five-year term of appointment members undertake a peer reflection process. A group of members (usually 4-6) will provide structured feedback via an online survey of their observations of how the relevant member approaches and performs in their role. The survey questions are derived from the Tribunal's competency framework and principles of conduct. The member also completes an identical self-appraisal and the results are collated in a comprehensive report. The report is reviewed by the Deputy President or President before being forwarded to the member, after which there is a follow up discussion.
- The Tribunal is a member of the Council of Australasian Tribunals (COAT)⁸ which grants it access to a range of tailored resources for tribunals and tribunal members – for instance the COAT Tribunal Excellence Framework informs various aspects of our administrative and quasi-judicial operations. Members are always informed of and encouraged to participate in professional development activities that are facilitated by the Victorian Chapter of COAT which generally include one conference and one twilight seminar each year.

⁸ For details see the Council of Australasian Tribunals website: www.coat.asn.au.

Appendix A. Case management case studies

'Sandra'

Sandra had been an inpatient in an extremely restricted setting for a number of years. Sandra, her family, legal representative and treating team all agreed it was time for her to 'step-down' to a less restrictive setting, but concerns were emerging that there may be impediments and delays to this happening.

Sandra's treating team applied to the Tribunal for a further six-month Inpatient Treatment Order (ITO). At the hearing no one opposed the making of a further Order, but the hearing was used as a forum for extensive discussion about proposed next steps and some of the hurdles to progress. The Tribunal made a six-month ITO but took the further step of writing to the parties summarising the discussion at the hearing and provided a detailed outline of the information it would require for the next hearing. It also confirmed that it proposed to join as a party to the next hearing the service that would be responsible for treating Sandra whenever she left the current service (the 'receiving service'). The receiving service was also notified that it would be joined as a party to the next hearing and required to provide certain information. The Tribunal emphasised that this information could be provided in collaboration with the current service.

At this point the Tribunal had to effectively 'withdraw'. As Sandra's hearing had been finalised it had no authority to monitor progress. The Tribunal could only re-engage upon receipt of an application for a further Treatment Order. As anticipated an application was made by Sandra's treating team, the application needed to be finalised by the Tribunal within two weeks. In this timeframe all the Tribunal could do was formally join the receiving service, confirm the hearing date and effectively 'hope' that at the next hearing there would be reports of progress towards Sandra's goals.

At the second hearing the current service and the receiving service presented a comprehensive treatment plan and discharge strategy that had been developed in consultation between the two services, Sandra and her family. The plan was creative, for example, it involved 'staff exchanges' in the lead up to discharge to share strategies about how best to support Sandra and respond to her needs. It was also long-term and had considered various contingencies and issues. The expectation was that transition from the current to the receiving service could happen in four to six weeks.

The transition plan was the product of the exemplary efforts of the two services, which worked in close collaboration with Sandra, her family and legal representative. The parties acknowledged that the Tribunal's case management approach used for these hearings had played an important role in advancing progress in what was an exceptionally complicated set of circumstances.

'Alan'

Alan is in his forties. He receives the Disability Support Pension and his supportive family also provide additional resources. Alan's case manager explained he describes himself as retired; he has declined assistance to explore options for part-time employment. He enjoys exercising and daily visits to several local businesses where he is well known and welcome.

Alan's medication consists of fortnightly depot medication and benztropine tablets. His diagnosis is schizoaffective disorder. He has been on a Community Treatment Order (CTO) continuously since 2018. His most recent hearing was held to determine his treating team's application for a further 12-month CTO.

Alan did not want to participate in the hearing and was not interested in reading the report prepared for the hearing. At the hearing Alan's case manager (who had known him for a number of years) explained that she had supported Alan to have his Treatment Order revoked on two occasions prior to 2018. On each occasion he remained on his medication for one to two months, but then had a disagreement with his GP, reduced his medication – as he was entitled to do as a voluntary patient – and eventually ceased contact with his GP. On each occasion Alan's case manager was contacted by the local business owners he visited. They reported he had become increasingly abusive and had been barred from visiting, it was also reported that he was speeding and driving erratically in the area.

At the time of this hearing Alan had a good relationship with his treating team. Alan was attending appointments and there had been no interruptions to his medication. When talking with his psychiatrist and case manager Alan explained he respected the Treatment Order and therefore adhered to treatment, but he also acknowledged he doesn't get as angry or upset about things when engaged with treatment. Alan's treating team assisted him to resolve issues with VicRoads. In response to Alan reporting some side-effects his medication dosage had been reduced.

The Tribunal was conscious that if granted this application would be Alan's third, consecutive CTO. However, it was satisfied the situation was not static – while the notion of having a mental illness was not something Alan identified with, nonetheless he and his treating team were engaged in an ongoing dialogue about his treatment and he was being provided with the broader supports he chose to accept and which appeared to support his individual goals. The Tribunal made a 12-month CTO.

Appendix B. Solution-focused hearing case studies

'Dany's' case – exploring broader issues

It may be that a consumer or carer wishes to talk about issues not strictly related to the matters determined by the Tribunal. In endeavouring to be solution-focused the Tribunal must guard against 'issue creep.' At the same time appropriately contained discussion of issues that may otherwise fall within another forum (such as a complaint body) can be difficult to avoid, and if they are shut down inflexibly, the Tribunal hearing can leave behind a magnified dispute. Issues might not be resolved in a hearing but a way of continuing the discussion and next steps might emerge.

During Dany's hearing, Dany's family members raised their dissatisfaction with what they considered to be poor communication with the treating team and concerns regarding some specific aspects of Dany's care. For example, they provided background information and explained that, as Dany had been a victim of abuse, she reacted adversely to restraint and lacked trust in people she was not familiar with. Dany's family offered some guidance as to how to encourage Dany's engagement with treatment.

During the hearing, Dany's doctor also had an opportunity to respond to specific medication and nursing issues raised by Dany's family and provided her perspective on some of the complexities around Dany's health and treatment during her most recent admissions. The Tribunal encouraged discussion about what might be done differently. The treating team and Dany's family decided to establish a single point of communication to avoid further difficulties and support Dany in her recovery. Everyone at the hearing agreed that a referral to a dual disability service would be constructive.

The Tribunal decided to make a Treatment Order for a duration that was considerably less than the treating team's initial request. The Tribunal noted that Dany had received treatment for many years previously without the need for a Treatment Order and expressed the hope that as she recovered and the ideas discussed in the hearing were implemented, Dany would once again be able to be treated on a voluntary basis.

'Jack's' case – exploring different perspectives about what will and won't work

Jack lived in youth accommodation designed for young people who wish to study but who are either homeless or at risk of homelessness. Jack had virtually no contact with his family. He had some history of engagement with mental health services prior to this most recent admission. Jack's treating team was seeking an Order for three months on the basis that Jack did not accept that he had experienced a relapse of his mental illness, noting that Jack's view was that he had anxiety for which he did not need medication (at the time of the hearing he was receiving depot and oral medication).

Jack attended the hearing with the manager and two case managers from his accommodation service. He told the Tribunal that he could not recall the events surrounding his return to hospital, did not think he needed to come to hospital and did not require treatment for mental illness. He was concerned about the side effects of his medication and that the medication obstructed his work and study. The staff from Jack's accommodation agreed that Jack was struggling to deal with his mental illness and that he needed support. It was acknowledged that previously there had been little or no coordination between Jack's treating team and the accommodation service.

As part of the hearing materials the Tribunal was provided with an occupational therapist's report indicating that Jack did not respond to coercion. Jack and one of his accommodation case managers confirmed that he preferred autonomy and independence. During the hearing there was discussion about the importance of coordination between the mental health team and the team at Jack's accommodation. The Tribunal was told that Jack was a very able and well-regarded person at his accommodation and there was evidence that he responded well when he was in an environment that he wanted to be in. There was discussion with Jack and the case managers from the accommodation service about dealing with any concerns about treatment (including side effects) with the treating team.

The Tribunal revoked the Order on the basis that there was a less restrictive means reasonably available to treat Jack – that is the Tribunal was satisfied that Jack could engage in treatment on a voluntary basis. Jack's stable accommodation, supportive surroundings and case managers, and the fact that he did not respond to compulsion, were important factors in the Tribunal's consideration. In this matter, all participants in the hearing used the Tribunal process as an opportunity to further share their own perspective and listen to the perspective of others in such a way as to identify options that hadn't previously been explored.

'Tony's' case - engaging with carers and family members

Tony was admitted to hospital as a compulsory patient when he was found walking down the road naked and acting bizarrely. Although Tony's mental state had improved significantly by the time of his Tribunal hearing, the treating team was concerned he was still recovering from his relapse and that he did not have stable accommodation. They were also concerned that Tony had indicated that he planned to travel to his father's country of origin to participate in certain ceremonies and practices. The treating team believed these were grandiose beliefs and symptoms of Tony's mental illness. The Tribunal was asked to make an Inpatient Treatment Order.

For his part, Tony was very frustrated that the treating team did not believe what he told them about the ceremonies that he maintained were of deep cultural significance to him and his family. Tony wanted to be treated in the community and to travel to attend his cultural ceremonies. Tony's mother, who lives overseas, travelled to Australia to attend the hearing. The treating team had not had a chance to speak with her before the hearing. They were surprised when she confirmed that Tony's father was a Chief in Tony's country of origin and that he was encouraging Tony to visit to complete initiation ceremonies and other cultural practices.

The Tribunal facilitated a discussion between Tony, Tony's mother and the treating team about the possibility of allowing Tony to leave hospital. Tony's mother was very supportive of Tony being discharged. She said she had arranged short-term accommodation for two weeks and would live with him and support him until he was settled and had secure accommodation. Both Tony and his mother agreed that Tony should not travel overseas immediately because he was still recovering from the acute relapse of his mental illness. Tony and his mother also agreed that they would work closely with the treating team and seek the treating team's advice regarding Tony's treatment and recovery and when he may be able to travel safely.

Taking into account a range of factors, including Tony's mother's support, Tony's willingness to have treatment and his views and preferences, the Tribunal was satisfied that the criteria for compulsory treatment were met but that it was appropriate to make a Community Treatment Order for only a relatively short duration. This meant that Tony was able to leave hospital on the day of the hearing.

'Jane's' case – focusing on what is most important to the consumer

Jane had lived with mental illness for many years and was in hospital after a recent relapse. Her hearing was triggered by her treating team's application for a further Inpatient Treatment Order for 26 weeks, although the information before the Tribunal explained that the treating team only wanted Jane to remain in hospital until her next depot injection, after which time they planned to vary the Order to a Community Treatment Order (CTO). Jane had recently been having leave each day and this had been going smoothly.

At the start of the hearing Jane was extremely angry and was reluctant to engage in discussion with anyone. The Tribunal did manage to engage Jane by focusing on her desire to go home. As Jane spoke, she explained that she understood there was a link between continuing with treatment and returning home as soon as possible. Following on from this the Tribunal explored with the treating team why Jane could not be discharged immediately on a CTO. Jane and her treating team then discussed how this might work. Following the considerable progress from the initial 'stand-off' at the beginning of the hearing the Tribunal made a CTO.

Appendix C. Consultation draft of a new hearing report template

dd/mm/yyyy

Patients name
Patients address 1
Patients address 2
SUBURB VIC Postcode

Statewide UR number:
Date of birth:

Dear [Patients name]

Our report for your Tribunal hearing

This report explains why we think you may need compulsory treatment and how we can help you recover.

We would like to discuss this with you at your Mental Health Tribunal hearing on dd/mm/yyyy. We will give the Tribunal a copy of this report.

The Tribunal members who will attend your hearing are independent of our health service. They will read this report and information from your medical file, listen to what you say and decide if your treatment will be compulsory.

The Tribunal members will make an Order saying that you must have treatment if they decide:

- a. You have a mental illness.
- b. You need treatment now to prevent a serious deterioration in your mental health or physical health, or serious harm to you or someone else.
- c. You will be treated now if you are on a Treatment Order.
- d. A Treatment Order is the only way to ensure you will get the treatment you need.

Your treating team

Consultant psychiatrist:
Medical officer:
Case manager:

Your personal background

The Tribunal wants to understand who you are and what your life has been like.

We understand that you are



a) Why we believe you have a mental illness

We believe that you currently have a mental illness because:

b) Why you need treatment

We think that you need treatment to prevent serious deterioration to your mental or physical health or serious harm to you or to someone else because:

c) How we will treat you if you were on a Treatment Order

We want to involve you in decisions about your treatment and recovery.

Here is a summary of the treatments we have tried and considered (including advantages and disadvantages, what you could try now and what we recommend):

d) Why compulsory treatment may be the only way to ensure you will get treatment you need

We think your treatment needs to be compulsory because:

Your views, preferences, hopes and goals

The Tribunal wants to understand what you think about your treatment and want for your future.

You have told us

Advance statement

You have:

- made an advance statement on dd/mm/yyyy which we will provide with this report.
- not provided an advance statement explaining your views and preferences. If you have one please let us know and bring it to your hearing.

Views of your family, friends and carers

How we can work with you towards your treatment being voluntary

If you would like to tell the Tribunal something or correct anything in this report you can do that using the **“What I want to tell the Tribunal worksheet”** included with this report.

We hope you can participate in your Tribunal hearing to talk about your treatment and recovery. If you do not participate the Tribunal will have to make a decision without you.

Yours sincerely

Dr
Consultant Psychiatrist