



Guide to solution-focused hearings in the Mental Health Tribunal

Second edition

February 2021

Mental Health Tribunal

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Use of Dr Michael King's Solution-Focused Judging Bench Book

With the permission of Dr Michael S King and the Australasian Institute of Judicial Administration Incorporated (AIJA) and the support of the Legal Services Board of Victoria, this *Guide to Solution-focused Hearings in the Mental Health Tribunal* draws heavily from Dr King's *Solution-Focused Judging Bench Book* (the Bench Book), which was published by the AIJA and prepared with the assistance of grants from the AIJA and the Legal Services Board.

While the Legal Services Board provided a grant for the Bench Book, the contents of the Bench Book do not represent the work of the Legal Services Board and any statements of fact, law or practice contained within the Bench Book cannot be attributed to the Legal Services Board.

Use of Recovery Oriented Language Guide

The New South Wales Mental Health Co-ordinating Council's (NMHCC) *Recovery Oriented Language Guide* complements a solution-focused approach to hearings. The guide has an emphasis on language that conveys hope and supports and promotes a recovery-oriented culture along with practical tips and suggestions for substituting worn-out words with language of acceptance, hope, respect and uniqueness. The NMHCC has kindly granted us permission to include the *Recovery-Oriented Language Guide* as an Appendix to this Guide.

A note about language

A note about language

There are diverse views on the most desirable or acceptable terms to use when referring to people who access mental health services (and who may receive compulsory treatment). These terms include 'consumers', 'clients', 'services users', 'people with lived experience', 'persons with mental illness' and 'patients'. Wherever possible – for example, where techniques described can apply to Tribunal hearing participants generally – this Guide uses the term 'participant'. However, where it is necessary to refer specifically to the person who is the subject of the hearing, this Guide generally uses the term 'consumer' or the term 'patient' (which is a defined term in section 3(1) the *Mental Health Act 2014* and means a compulsory, a security or a forensic patient).

The former Department of Health's *Framework for recovery-oriented practice* (2011) referred to later in this Guide notes that many people do not identify with the term 'carer' and the kind of relationship this term implies. The Interim Report of the Royal Commission into Victoria's Mental Health System notes that the word 'carer' does not capture the diversity of relationships. For this reason, this guide employs the broad terms 'support people' or 'support networks' as well as 'carers'. Chapter 9 which focuses on involving family, friends, carers and other support people in hearings also uses terms and phrases such as 'families,' 'family members' or 'family, friends, carers and other support people.

Foreword to the second edition

The Mental Health Tribunal (Tribunal) adopted a solution-focused approach to hearings as part of its commitment to embody and promote the reforms enshrined in the *Mental Health Act 2014* (the Act). As a framework of practice the solution-focused approach has been invaluable. It has supported and challenged us to conduct hearings differently – as should be the case in this unique jurisdiction. It has equipped us to reflect critically on our approach, and guided our collaborative work with consumers, carers and mental health services to identify improvements.

This second edition of the *Guide to Solution-Focused Hearings in the Mental Health Tribunal* captures the experience of the Tribunal over the past several years. It includes chapters that explore the specific needs of younger and older consumers, and how to most effectively promote the participation of carers and the broad range of support people involved in hearings. Case studies based on real hearings provide tangible examples of what a solution-focused approach can mean in practice, while added new sections explore how a solution-focused approach can assist in handling some of the most complex issues that arise in hearings.

A constant theme through this edition is the link between a solution-focused approach and the mental health principles enshrined in the Act. When performing its functions the Tribunal must have regard to the mental health principles. This obligation applies to our administrative operations as well as in the context of hearings and decision making. The mental health principles reflect what the Supreme Court has described as the ‘paradigm shift’ intended by the Act. They emphasise voluntariness, respect for autonomy, supported decision making, holistic treatment and recovery, community participation, the dignity of risk, and respect for and involvement of carers.

A solution-focused approach is one of the tools used by the Tribunal to enliven these principles. For instance, adopting a solution-focused approach to the exploration of less restrictive alternatives reminds us that even if a less restrictive option is not possible at the time a decision is being made by the Tribunal, we should take the time to discuss what might be possible in the future and the pathway to less restrictive treatment. With its emphasis on communication a solution-focused approach also makes us alert to the impact of how we speak to people and to always use words and language that convey kindness and respect. To this end, the second edition is informed by the work of speech pathologist, criminologist and courage facilitator, Rosalie Martin, and includes the *Recovery Oriented Language Guide* of the NSW Mental Health Co-ordinating Council as an appendix.

We are finalising the second edition while eagerly awaiting the final recommendations of the Royal Commission into Victoria’s Mental Health System. Undoubtedly we are once again on the cusp of significant reform. We are confident that our solution-focused approach equips us to respond to the challenge of reform, and to play a valuable role in the contemporary mental health system that Victorians expect and need.

PART 1 LEGISLATIVE AND THEORETICAL BACKGROUND

Chapter 1 Introduction and context

- This Chapter introduces the concept of solution-focused hearings and key sources used in this Guide.
- A solution-focused approach aims to engage participants as active partners in the hearing discussion and decision-making process of the Tribunal. Solution-focused techniques reflect the mental health principles in the Act and the provisions that promote the rights, dignity and autonomy of patients.
- [Dr Michael King's 2009 *Solution-Focused Judging Bench Book \(the Bench Book\)*](#) is a key source for the practical communication techniques and strategies described in this Guide. The Guide synthesises and tailors the Bench Book to make it relevant and accessible to Tribunal members and hearing participants. Many examples of communication techniques and all case studies are drawn from our practical experience of Tribunal hearings.
- This second edition of the Guide also draws on the New South Wales Mental Health Co-ordinating Council's (NMHCC) Recovery Oriented Language Guide which provides practical guidance on how to use language that conveys hope and supports and promotes a recovery-oriented culture.

1.1 Why use a solution-focused approach in Mental Health Tribunal hearings?

[The solution-focused] judging approach is, as far as possible, designed to engage participants in the resolution process and to see them as an important and active partner rather than a silent partner in the process. The bench book uses processes that promote participants having choices and being able to express their views, and having them taken into account and being treated with respect...¹

(Dr Michael King's Solution-Focused Judging Bench Book).

A solution-focused approach aims to engage participants in hearings as active partners in the discussion and decision-making process of a court or tribunal. A solution-focused approach is not about miscasting the Mental Health Tribunal (the Tribunal) as a source of solutions. Rather, a solutions-focused approach recognises that hearings can be conducted in a manner that facilitates participants discussing, identifying and committing to future actions or solutions. This approach is based on the premise that the best outcomes are achieved when participants in these processes are key players in formulating and implementing plans to address the underlying issues that have led to their participation in the process.

Apart from the fact they are grounded firmly in contemporary thinking and research, a key justification for using solution-focused techniques in the Tribunal is that they complement the mental health principles and reforms in the *Mental Health Act 2014* (the Act), particularly those principles and provisions that promote the rights, dignity and autonomy of patients and to support them to make or participate in decisions about their assessment, treatment and recovery. The synergy between a solution-focused approach and the Act can help achieve positive outcomes for Victorians receiving compulsory treatment for a mental illness.

As discussed in Chapter 2, therapeutic jurisprudence commentators have suggested that when practices fail to facilitate the participation of consumers in hearings and respect their dignity, it can produce negative psychological consequences that may in turn 'exacerbate ... mental illness' and 'have a significantly adverse impact on the ability of patients to respond successfully to hospitalisation and treatment'.² As a corollary, adopting a solution-focused approach to hearings can contribute to, and potentially enhance, the therapeutic relationship between consumers and their treating teams in a hearing.

In this way, promoting a solution-focused approach also recognises that a hearing before the Tribunal is not a mere 'procedural adjunct' to a person's treatment and overall experience of the mental health system. Rather, it is an integral and non-negotiable part of that experience when they are being treated compulsorily.

In summary, in a jurisdiction such as the Tribunal, a member's role is not simply about applying the 'black letter' of the law. Rather, it is about actively facilitating an approach to hearings that promotes the objectives and principles of the Act, including to promote the recovery of persons who have mental illness and to enable and support persons with mental illness to participate in decisions about their treatment and recovery. Adopting a solution-focused approach greatly enhances a member's ability to fulfil this broader role.

This Guide is not intended to operate as a set of rigid rules to be adopted in all cases. It is a broad approach or 'ethos' to inform self-reflection on hearing practices rather than a 'script' that must be followed. In deciding how to use the techniques outlined in this Guide, members will still need to rely on their common sense, intuition and experience.

1.2 Dr Michael King's Solution-Focused Judging Bench Book

Part 1 and particularly Part 2 of this Guide which focus on practical techniques to promote solution-focused hearings are based closely on Dr Michael King's 2009 *Solution-Focused Judging Bench Book* (King's Bench Book or the Bench Book). King's Bench Book provides an invaluable explanation of best-practice solution-focused hearing techniques that can be used in so-called 'problem-solving' courts or court programs (such as drug courts and family violence courts) as well as in mainstream courts and specialist civil tribunals such as the Tribunal.

Terminology and language

King prefers the term 'solution-focused' to 'problem-solving' as the latter term may imply that courts or tribunals solve the problems of participants for them.³ The term 'solution-focused' reflects that the role of the court or tribunal, and its supporting administrative structures, is more about facilitating dialogue and supporting participants to develop their own solutions. The concept of 'solution-focused' hearings is explored further in Chapter 2.

In addition, this Guide generally uses the term ‘solution-focused hearings’ rather than ‘solution-focused judging’. This reflects the fact that many of the techniques described in this Guide are broader than the term ‘judging’ implies.

Wherever possible, particularly where the solution-focused techniques described can apply to hearing participants generally, this Guide uses the term ‘participants’ rather than terms such as ‘patients’ or ‘service users’ (see *A note about language* at the start of the Guide). This is partly to emphasise one of the main aims of the solution-focused hearings approach – to encourage the participation of consumers in hearings – as well as to reflect the fact that many techniques and strategies in this Guide will be used or adapted for use with other participants in hearings. These participants may include carers, family members, significant others and other support people, nominated persons, the treating team and legal and non-legal advocates.

Note that in Parts 3 and 4 which focus on particular groups of consumers or their family, friends, carers and support people, or particular themes arising in hearings, the Guide adopts language that more specifically identifies the participants that are the focus of discussion.

A focus on practical strategies

King’s Bench Book provides practical advice about techniques which judicial officers can adopt in hearings. The Bench Book also provides a helpful summary of research and theories that inform the solution-focused approach. While the main concepts are covered in this Guide, members and other readers interested in learning more about the theories underlying solution-focused judging are encouraged to consult King’s Bench Book.

Adapting the Bench Book for the Mental Health Tribunal

This Guide synthesises and tailors the Bench Book to the context of the Tribunal and makes it relevant and accessible to members and other interested readers. As part of this tailoring process, many examples of communication techniques and all case studies are drawn from our practical experience of Tribunal hearings.

In addition, one useful and highly relevant source of research referred to frequently in this Guide is the monograph by Professor Terry Carney et al titled *Australian Mental Health Tribunals: space for fairness, freedom, protection & treatment?*⁴ That study was published in 2011 (and much of the research was conducted earlier than 2011) and so it predates the reforms introduced by the Act and the establishment of the Tribunal. With the caveat that much has changed and changed dramatically in terms of the law and hearing processes, the monograph nevertheless identifies some themes that remain relevant.

This consolidation

This second edition of the Guide updates the first edition and includes additional elements of the Tribunal’s solution-focused framework. Over the past six years, the Tribunal has explored how particular strategies can be employed to conduct solution-focused hearings for participants with distinct, specific needs. We have also used a solution-focused ‘lens’ to explore complex issues that frequently arise in hearings.

This edition also incorporates the New South Wales Mental Health Co-ordinating Council’s (NMHCC) *Recovery Oriented Language Guide*.⁵ That guide’s emphasis is on language that conveys hope and supports and promotes a recovery-oriented culture. It also makes practical suggestions for substituting worn-out words with a language of acceptance and hope.

This Guide is not a static resource and we will continue to pursue further additions and enhancements.

¹ Michael S King, 2009, *Solution-Focused Judging Bench Book*, Australasian Institute of Judicial Administration Incorporated, Melbourne, p. 2.

² Fleur Beaupert 2006, 'Aspects of mental health tribunal processes that may impact on their 'therapeutic' potential,' a paper presented to the Third International Conference on Therapeutic Jurisprudence, Perth, Western Australia, 7-9 June 2006, pp. 1-24, 4; quoting B J Winick, 'A Therapeutic Jurisprudence Model for Civil Commitment' in K Diesfeld and I Freckelton (eds), 2001, *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment*, Aldershot, Hampshire, Ashgate, pp, 23-54.

³ Ibid, p. 5.

⁴ Terry Carney, David Tait, Julia Perry, Alikki Vernon & Fleur Beaupert, 2011, *Australian Mental Health Tribunals: space for fairness, freedom, protection & treatment?* Law and Justice Foundation of NSW, Adelaide.

⁵ New South Wales Mental Health Coordinating Council (NMHCC), 2018, *Recovery Oriented Language Guide*, second edition.

Chapter 2 What are solution-focused hearings?

- This Chapter explores solution-focused hearings and some of the concepts underpinning a solution-focused approach.
- Solution-focused hearings adopt communication techniques which support and encourage meaningful participation in hearings.
- The key concepts behind these techniques are: therapeutic jurisprudence; self-determination and autonomy, participation; and the idea of an 'ethic of care'.
- Therapeutic jurisprudence suggests basic principles associated with motivation and positive behavioural change should inform a solution-focused approach. Two of these principles are self-determination or autonomy, and procedural justice values.
- Respecting autonomy builds motivation, confidence, satisfaction and the opportunity to develop life skills. Improving the autonomy of participants by supporting them to be involved in or make decisions about their treatment is also essential for good mental health.
- The Tribunal aims to support the autonomy of patients by encouraging their participation in hearings and facilitating dialogue between them and their treating team.
- Procedural justice offers important insights into how members can interact with participants in hearings. Key concepts include neutrality, respect, participation and trustworthiness.
- Encouraging participation is important because it shows respect for consumers and their views and preferences.

The practical strategies outlined in King's Bench Book and this Guide are communication techniques, which research and experience have shown support and encourage effective participation in hearings.

The following passages from the Bench Book encapsulate the solution-focused approach:

Solution-focused judging is based on the premise that participants ... should be key players in the formulation and implementation of plans to address their underlying issues and associated legal problems.⁶

Judging in a solution-focused manner involves a more personal approach. The aim is to develop a rapport between judicial officers and participants whereby the judicial officer can use a range of therapeutic judging strategies to support and encourage participants through the change process. The judicial officer takes an interest in participants – their thoughts, feelings, dreams, goals; what is happening in their lives; and their strengths and weaknesses. In interacting with participants, the judicial officer is mindful of

*avoiding language and forms of interaction that demean or depersonalise the participant.*⁷

*The judicial officer should use skills that promote participant trust in the judicial officer, including communication and listening skills and skills that promote participant self-determination, problem-solving and self-efficacy.*⁸

*Essentially the approach [is] for the judicial officer to engage with defendants, see them as whole human beings with strengths, weaknesses and solutions, actively involve them in decision making directed at promoting their rehabilitation, take an active interest in and support their progress and, as far as possible, use techniques that promote them developing a solution in the event that a problem arises.*⁹

However, the concept clearly extends beyond the summary provided in these extracts and the rest of this Guide explores what is meant by a solution-focused approach in the context of the Tribunal.

The next section of the Guide starts this process of exploration by introducing key concepts and theories that have informed the development of a solution-focused approach. These include (among others): therapeutic jurisprudence; self-determination and autonomy; participation; and the idea of an 'ethic of care'.

2.1 Therapeutic jurisprudence

Therapeutic jurisprudence studies the effect of the law and legal processes on the wellbeing of people affected by them.¹⁰ In the context of Tribunal hearings, the people affected could include patients, family, friends, carers and other support people, members of the treating team, legal representatives as well as Tribunal members themselves.

Therapeutic jurisprudence is derived from the behavioural sciences and recognises that while the law should ideally do no harm, in some cases 'some harm is possible but it may be minimised through the use of therapeutic jurisprudence techniques'.¹¹ According to King:

*Therapeutic jurisprudence is a mechanism for promoting law reform using wellbeing as the lens through which the law is studied and the behavioural sciences as the source of possible remedies that could be adapted for use within the legal system. It sees a commonality between the law and the behavioural sciences in their interest in the functioning of the human psyche and how healthy behaviour may be promoted.*¹²

Therapeutic jurisprudence is said to be the jurisprudential foundation for special intervention or problem-solving courts and it informs the solution-focused approach to hearings. According to King, it does more than suggest some techniques that can be used in hearings:

*[Therapeutic jurisprudence] suggests that there are basic principles associated with motivation and positive behavioural change that are based on empirical research that should inform all judging and advocacy practices in problem-solving courts.*¹³

Two of these basic principles are the principles of self-determination and the promotion of procedural justice values. These principles are explored in the following

sections, along with other principles informing a solution-focused approach such as participation, ethic of care and holistic approaches.¹⁴

2.2 Self-determination and autonomy

King states that self-determination or autonomy has been ‘regarded as vital for health, motivation and successful action in various traditions and disciplines over hundreds of years’.¹⁵ Self-determination allows participants to choose action that is personally meaningful for them and which they have an internal commitment to perform. Providing this choice can promote the motivation, confidence, satisfaction and opportunities of participants to build important life skills.

In the mental health context, improving the autonomy of participants is essential for good mental health, as Carney et al indicate:

*It is important to consider that autonomy and self-management are not only a human right, they are essential pre-requisites to mental health. Institutionalisation and control through CTOs, while they may be necessary for those who are incapable of caring for themselves, or likely to cause harm to others, also have an adverse psychological effect on the person’s capacity for independence, dignity, self-confidence and self-regard. Ensuring that the client has a role and understands the process, and that all involved in the process work collaboratively and respectfully with the client in the management of mental illness, is likely to lessen these negative effects.*¹⁶

This conclusion is illustrated in the same publication by the following comment from a Victorian consumer:

*[P]eople, once they started interacting with the doctors and psychiatrists with their own treatment, they feel more positive, you feel more in control of your own destiny and life, you feel like you are doing something for yourself and you are not just being told what to do. (Victorian consumer, focus group, v23)*¹⁷

As highlighted in Chapter 3, self-determination and autonomy are key themes in the Act. This indicates that a solution-focused approach can help to give full effect to the Act and its underlying goal of taking a recovery-oriented and patient-focused approach to the treatment and care of people with severe mental illness.

The Victorian Supreme Court has also made it clear that an individual’s autonomy contributes to their health as the following passage from Justice Bell’s decision in *PBU & NJE v Mental Health Tribunal* indicates:

*[...] the concept of health in the Mental Health Act is broad and recognises the two-way relationship between self-determination, freedom from non-consensual medical treatment and personal inviolability on the one hand and the person’s health on the other. Mental Health treatment decision-making is not a simple best-interests trade-off between the person’s autonomy and health because health is a broad concept that relates to the whole person of which the person’s autonomy, while not absolute, is a constitutive element.*¹⁸

Exactly how much the Tribunal can facilitate self-determination and autonomy in individual cases is a matter of degree and will depend on a number of factors including, for example, the extent to which a person may be experiencing acute symptoms of an illness or the side-effects of treatment at the time of the hearing. It also requires engagement by the person’s treating team. The representative/s of the

treating team need to know the person and be in a position to respond to issues they raise. To the greatest extent possible, the Tribunal aims to support the autonomy of patients by encouraging their participation in hearings and facilitating dialogue between the patient and their treating team.

2.3 Promotion of procedural justice values

The field of procedural justice offers important insights into how members can interact with participants in hearings.¹⁹ Four key components of procedural justice are neutrality, respect, participation and trustworthiness.

Neutrality refers to the duty of members to act independently and free from bias.

Respect in the procedural justice context involves members affirming participants in hearings as competent, equal citizens and human beings.

Participation is about ‘giving people the opportunity to explain their situation in circumstances where the person in authority is actually listening to what they say’.²⁰ It’s worth noting that facilitating participation is not confined to the approach that members take in the hearing itself. To prepare for the hearing and engage more fully in it, participants need to know about the hearing and what to expect during it. This means the Notice of Hearing and documents included with it (such as information sheets) is an important first step in facilitating participation in hearings.²¹

Trustworthiness relates to the perceptions of participants about the motives of members, and whether members truly care about them and demonstrate an ‘ethic of care’ (for more on this concept, see [section 2.4](#)).

More guidance about key aspects of the related concept of procedural fairness – particularly the hearing rule and the bias rule – is provided in the [Guide to Procedural Fairness in the Mental Health Tribunal](#).

2.3.1 Participation

Participation is a key component of solution-focused hearings. King notes that participation means ‘being treated with respect and the trustworthiness of the judicial officer’ and being able ‘to tell one’s story to a legal authority who listens and takes what is said into account and/or being involved in shared decision making’.²²

Encouraging meaningful participation is important because it gives participants the feeling they are being treated with dignity and respect and because, by actively participating, consumers are able to communicate their views and preferences. Active participation of all parties enables the Tribunal to be informed of all relevant issues and perspectives, which improves the prospects of a legally accurate outcome.²³

The active participation of persons in hearings is also important from a human rights perspective. As Dr Penelope Weller observes:

From a human rights perspective, participation of the person in all matters and decisions concerning them flows from the recognition that the principles of equality and non-discrimination are universally applicable. People with mental illness or other mental disabilities are therefore entitled to be recognised before the law on the same basis as other people, and are entitled to receive such support and assistance as is necessary to enable them to do so. From a human rights perspective legal decisions that proceed without the participation of the person are suspect.²⁴

It's also worth noting that participants are more likely to accept the decisions of the Tribunal if the processes are seen as fair and legitimate. Encouraging participation is a fundamental way of ensuring this is the case.²⁵

2.4 Ethic of care

The term 'ethic of care' (sometimes referred to as 'ethics' of care²⁶) encapsulates the approach that members take in solution-focused hearings.²⁷ Grounded in the focus of therapeutic jurisprudence on the therapeutic *application* of the law, the concept of an ethic of care is most visible in hearing processes and the way participants relate to each other in hearings.²⁸

For example, an ethic of care involves being sensitive to the communication needs of participants.²⁹ This may include using simple words rather than jargon. It may also include making several attempts to ensure that participants are aware of the critical issues to be determined at the hearing.³⁰

South Australian Deputy Magistrate Andrew Cannon has summarised this approach as:

It is a respectful and proactive engagement with people involved in the court process to pay attention to their needs, rather than a neutral but mechanical and unsatisfying closing of files. It is a more exposed judicial role compared to the relatively mute and remote figure who only pronounces at the end and then in detached language.³¹

2.5 Holistic approaches

In the context of solution-focused hearings, King describes a holistic approach as seeking 'to provide assistance to participants where needed and appropriate in major life domains, such as health ..., employment and training, accommodation, financial planning, other life skills, recreation and relationships'.³² Holistic approaches see participants as 'whole human beings with strengths, weaknesses, threats and opportunities'.³³

This approach is consistent with non-adversarial justice and respecting the human rights of participants, as Weller observes:

Understanding the compatibility of non-adversarial justice and human rights points to the importance of creating MHRTs that are engaged with a holistic account of the experience of each person who appears before the [tribunal]. More importantly, it provides a solid theoretical grounding for an expansion of tribunal powers.³⁴

In the following passage from the Minister's Second Reading Speech it is clear the Act is intended to promote a holistic approach rather than a narrow focus on the criteria for compulsory treatment:

*The Tribunal is expected to take a holistic approach when it makes determinations and consider a range of factors, including the patient's goals, preferences and aspirations and the views of other people who are significant in the life of the patient, such as the nominated person and carers.*³⁵

The Supreme Court of Victoria has confirmed that treatment decisions under the Act should not 'be based on purely medical grounds but, where appropriate, should also encompass holistic consideration of patients in their entire personal and social setting'.³⁶ A holistic approach is consistent with the objectives and principles in the Act which reflect the right to self-determination (including to be free of non-consensual medical treatment) and to personal inviolability.³⁷

Finally, research by Carney et al also indicates that many participants in hearings prefer a broader discussion that explores more than just medical issues but also other aspects of their lives, such as housing circumstances, social networks and general capacity to function socially.³⁸ Adopting a holistic approach addresses this expectation.

2.6 Other approaches

The Bench Book discusses other approaches and theories related to the solution-focused approach to hearings. These are: transformational leadership, creative problem solving and restorative justice.

Members and other readers interested in learning more about these approaches are encouraged to read [Chapter 1 of the Bench Book](#).

⁶ Michael S. King, 2010, 'Judging in problem-solving courts, indigenous sentencing courts and mainstream courts,' (2010) vol. 19 *JJA*, pp. 133, 137.

⁷ King Bench Book, above n 1, p. 157.

⁸ Ibid.

⁹ Ibid p. 33, Quotation is from M S King and B Batagol, 2010, 'Enforcer, Manager or Leader? The Judicial Role in Family Violence Courts,' *International Journal of Law and Psychiatry*, Nov-Dec; 33 (5-6): pp. 406-416.

¹⁰ Michael S King, 2008, 'Restorative Justice, Therapeutic Jurisprudence and the rise of emotionally intelligent justice,' *Melbourne University Law Review*, vol. 32, pp. 1096-1126, 1111.

¹¹ King Bench Book, above n 1, p. 24.

¹² Ibid.

¹³ Ibid, p. 26.

¹⁴ Ibid. King also mentions 'health compliance techniques'. These are discussed briefly in Chapter 6 of this Guide.

¹⁵ Ibid. This section is generally drawn from King Bench Book, above n 1, pp. 26-28.

¹⁶ Carney et al, above n 4, pp. 295-296.

¹⁷ Ibid, p. 267.

¹⁸ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, [104].

¹⁹ King Bench Book, above n 1, p. 28. This section is generally drawn from King Bench Book, pp. 28-35.

²⁰ Ibid, p. 29.

²¹ The Tribunal has undertaken and continues to undertake considerable work in this area in consultation with the Tribunal Advisory Group (TAG), made up of consumers, carers and peer workers. For example, in 2019 the Tribunal launched a new website designed to make it easier for consumers to understand what happens at the Tribunal, prepare for hearings and to know how to

exercise their rights if they disagree with a decision of the Tribunal. In consultation with the TAG, the Tribunal has also improved the informational material provided to members with the Notice of Hearing as well as the Notice of Hearing itself. Part 3 of the Tribunal's Annual Report is the best source of information about recent and ongoing initiatives to improve participation in hearings.

²² King, above n 6, p. 145.

²³ Beupert, above n 2, p. 13, summarising Ian Freckleton, 2003, 'Involuntary Detention Decision-Making, Criteria and Hearing Procedures: An opportunity for therapeutic jurisprudence in action' in K Diesfeld and I Freckleton (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment*, Aldershot, Hampshire, Ashgate, pp. 293-337, 313.

²⁴ Dr Penelope Weller, 2010, 'Non-adversarial Justice and Mental Health Review Tribunals: a reflexive turn,' presentation delivered at conference on *Non-adversarial Justice Conference: Implications for the Legal System and Society*, Melbourne, 4-7 May 2010, p 7

²⁵ Ibid.

²⁶ Beupert, above n 2, p. 5.

²⁷ King Bench Book, above n 1, p. 29.

²⁸ Beupert, above n 2, p. 5.

²⁹ Ibid p. 9.

³⁰ Ibid.

³¹ Quoted in King Bench Book, above n 1, p. 30.

³² Ibid, pp. 40-41.

³³ Ibid, p. 41.

³⁴ Weller, above n 21, p. 13.

³⁵ Victorian Parliamentary Debates, Legislative Assembly 20/02/2014, pp. 470, 477.

³⁶ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, [101].

³⁷ Ibid.

³⁸ Carney et al, above n 4, pp. 222-224, under the heading 'Including life factors in the evidence'.

Chapter 3 Solution-focused hearings and the Act

- This Chapter highlights synergies between the Act and a solution-focused approach to hearings.
- The Act sets down 12 mental health principles to guide persons performing duties, functions or exercising powers under the Act. This includes members of the Tribunal. The principles focus on least restrictive treatment and promote recovery and full participation in community life. They emphasise that consumers should be involved in all decisions about their treatment and recovery and supported to make, or participate in, decisions. The principles also state that the rights, dignity and autonomy of persons receiving mental health services should be respected and promoted.
- Solution-focused hearings are one of the main ways the Tribunal seeks to embed the mental health principles in hearings. Facilitating the active participation of consumers in the hearing process can be a meaningful step towards supported decision making and autonomy.
- This Chapter highlights how statutory tests in the Act reinforce the principles. For example, in most statutory tests the Tribunal must consider, to the extent that is reasonable in the circumstances, a patient's views and preferences about their treatment and the reasons for those views and preferences, including any recovery outcomes a person would like to achieve.
- The inquisitorial and informal nature of the Tribunal is enshrined in the Act. This gives the Tribunal the scope and flexibility to adopt solution-focused techniques. For example, it enables discussion about issues that a patient wants to talk about which are not directly related to the matters to be determined by the Tribunal. The meaning of recovery and recovery-oriented practice are relevant to several aspects of the Tribunal's role, including its consideration of risk.

The Tribunal will take a solution-focused and recovery-oriented approach to hearings. This will place the patient at the centre of the hearing, as an active participant in the discussion and decision-making process. The patient will be supported to discuss their thoughts, views, preferences and goals to enable problem-solving and promote self-determination. The overall goal of these hearings is to support patient progress toward voluntary treatment and recovery.

(Second Reading Speech for the Mental Health Bill 2014).³⁹

As the above quotation from the Second Reading Speech indicates, solution-focused hearing techniques complement many reforms in the Act.

This chapter highlights synergies between the Act and a solution-focused approach to hearings.

3.1 Objectives of the Act and the mental health principles

Consistently with the right to self-determination, to be free of non-consensual medical treatment and to personal inviolability, the objectives and principles [in the Act] emphasise enabling supported decision-making, and participation in decision-making, by the person (ss10(d) and (g), 11(1)(c)), including the exercise of the dignity of risk (s 11(1)(d)). There is emphasis on respecting the views and preferences of the person in relation to decisions about their assessment, treatment and recovery (s.11(1)(c)). Together with the operative provisions of the Mental Health Act, the objectives and principles are intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights.⁴⁰

(Supreme Court decision in PBU & NJE v Mental Health Tribunal).

The Act sets down 12 mental health principles in section 11(1) to guide the provision of mental health services and in the performance of any duty, function or exercise of any power under the Act. The principles apply to the Tribunal and to members.⁴¹

The full set of principles are extracted in the list below.

- Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.
- Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- 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.
- Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.
- Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.
- Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.

- Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.
- Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
- Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

Solution-focused hearings are one of the main ways the Tribunal seeks to embed the mental health principles in hearings. As the Tribunal's submission to the Royal Commission into Victoria's Mental Health System stated:

In particular, this framework of practice assists the Tribunal to manage an inherent tension that exists between the principles and our statutory functions. The Act seeks to promote supported decision making; however, Orders made by the Tribunal allow substitute decisions to be made regarding a person's treatment. A solution-focused approach does not erase this tension, but it can ameliorate it. Patients' active participation in the hearing process and the final outcome can be a meaningful step towards supported decision making and autonomy.⁴²

3.2 Self-determination and supported decision making including participating in decisions about treatment

The Act's focus on individual autonomy and supported decision making was highlighted in the Second Reading Speech (2014):

This bill provides a legislative framework that promotes recovery-oriented practice in the Victorian public mental health service system [...]

Recovery is about maximising individual choice, autonomy, opportunity and wellbeing during a person's life and accordingly is a self-defined process that is highly individual [...]

At the very heart of the bill is a supported decision-making model that will enable patients to make or participate in decisions about their assessment, treatment and recovery and to be provided with the support to do so.⁴³

Several years later, Justice Bell reinforced the paradigm shift the Act represents, stating that the less restrictive treatment test:

respects, to a much greater degree, the patient's right to self-determination, to be free of non-consensual medical treatment and to personal inviolability; one that is intended positively to promote patient participation and supported decision-making; and one that, in appropriate cases, incorporates recovery (and not simply cure) as an important therapeutic purpose in a holistic consideration of the person's health...⁴⁴

The Royal Commission into Victoria's Mental Health System also noted in its interim Report (2019):

Ensuring consumers are at the centre of decision making – and that mental health services are delivered in accordance with human rights in a way that promotes individual autonomy, respect and dignity – has been impressed on the Commission.⁴⁵

The focus on personal autonomy is timely and positive but also creates a complex challenge (and possibly even a tension) for the Tribunal to navigate. The Tribunal is a substitute decision-making body, but it needs to approach this role in a manner that leaves intact the greatest possible scope for the future exercise of personal autonomy and supported decision making by patients.

Mechanisms and provisions included in the Act that enable supported decision making include the presumption of capacity,⁴⁶ advance statements,⁴⁷ nominated persons,⁴⁸ the second psychiatric opinion scheme and the obligation on the Tribunal, and mental health clinicians – to have regard to a person's views and preferences about treatment of their mental illness whenever decisions are being made.⁴⁹

Solution-focused practices the Tribunal adopts to promote these principles or mechanisms include:

- accessible resources that provide clear information about the hearing and what to expect⁵⁰
- where necessary case managing hearings to ensure the right people are in the room to discuss the next steps
- involving nominated persons in hearings and confirming if a person has made an advance statement
- encouraging the participation of carers and other support people in hearings (see [Chapter 9](#))
- according weight to the input of a nominated person or the content of an advance statement or, in the event a consumer does not have a nominated person or advance statement, flagging these as something they may want to consider and discuss with their treating team in the future
- reminding hearing participants of the second psychiatric opinion scheme and/or Independent Mental Health Advocacy service where the discussion in a hearing suggests there is an entrenched disagreement that requires a 'circuit breaker'
- supporting consumers and the treating team in progressing the therapeutic process to include the individual's views and in adopting a holistic treatment approach
- providing a timely decision and, if requested, a Statement of Reasons.

It is clear that a solution-focused approach is related to and can support the key goals of supported decision making – namely to support consumers to take responsibility for their own mental health and other challenges, and to actively involve them in Tribunal decision making. Part of supporting consumers to make their own decisions or be involved in those decisions is to hear their views and preferences in the hearing. This is

explored in the following section and is the rationale behind most communication techniques described in Part 2 of this Guide.

3.3 **Ascertaining and responding to the views and preferences of patients**

Many statutory tests in the Act reinforce supported decision making and the autonomy of consumers in that the tests require the Tribunal to have regard to a patient's treatment preferences. For example, section 55(2)(a) of the Act requires the Tribunal, to the extent that is reasonable in the circumstances, to have regard to 'the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve'.

A solution-focused approach recognises that a unique series of experiences and events precedes a person being a patient at a particular point in time. If they are willing or wish to explain some of those circumstances, it is relevant and important for them to have the opportunity to do so. Compulsory treatment should never be regarded as an ongoing norm for any individual. Where possible, a pathway to less restriction and greater autonomy for a person should be explored, including what voluntariness truly means in the context of each person's circumstances, taking into account that people should be allowed to make decisions that involve a degree of risk.

A solution-focused approach facilitates a process that can provide an opportunity for those involved in hearings (consumers, their support people and clinicians) to explore issues and potential strategies to address difficulties. In some cases, it may simply be about timing – seizing an opportunity that hasn't presented itself before to discuss these issues. The case studies of 'Tony' and 'Ali' below illustrate this approach and how the Tribunal takes into account the views and preferences of patients. The case of 'Tony' is also explored in more detail in Chapter 9.

'Tony'

Tony's treating team asked the Tribunal to make an Order that would require him to remain in hospital for at least another three weeks. Tony was desperate to leave hospital for several reasons, including upcoming events that were of deep cultural significance to him and his family.

The Tribunal hearing was the first occasion Tony's mother had been available to meet with Tony and his treating team. The discussion that took place identified a collaborative strategy between Tony, his family and treating team that meant the Tribunal made an Order allowing Tony to be treated while living at home (and participating in the cultural events) rather than staying in hospital. In some cases, the Tribunal can be a forum to discuss and confirm positive developments already underway.

Tony's case illustrates that recognising progress, including having an independent body acknowledge what has been achieved, can potentially contribute to further positive outcomes.

‘Ali’

Ali was unhappy about being on a Treatment Order, had previously had a poor relationship with his treating team and had made numerous applications to the Tribunal to revoke his Order. He had a history of not adhering to treatment and numerous compulsory admissions over many years. Ali particularly disliked depot medication and had previously told the treating team that he planned to avoid this treatment by going ‘on the run’.

To avoid this scenario, the treating team and Ali had negotiated a new clinical treatment plan. In response to Ali’s concerns, Ali and his doctors had agreed on a less intrusive plan: Ali would start oral medication and be supervised daily by a pharmacist or the treating team for one month; he would then take oral medication unsupervised for one month; and medication would be on an as-needed basis for a subsequent month. Ali agreed to consultant reviews to assess side effects and the impact on his mental stability and mood, and to have ongoing contact with the community treating team. This approach took Ali’s views and treatment preferences into account and gave him a greater degree of agency and autonomy in managing his treatment. It also represented the development of a positive relationship with his case manager. The Tribunal acknowledged these improvements and recognised it was an achievement shared by both Ali and his treating team.

Based on the discussion in the hearing, Ali’s views changed. He had requested a hearing to have the CTO revoked but decided that it would actually be helpful to have the Order in place while these changes were made. Given that Ali and his treating team agreed, the Tribunal made a CTO with a duration that aligned with the previous Treatment Order. Both Ali and his treating team were happy with this outcome. Ali was reminded that should he change his mind, he could make another application to have the Order revoked.

3.4 Inquisitorial and informal nature of Tribunal hearings

The Tribunal is not legalistic or adversarial in nature. Rather, the Tribunal operates on an inquisitorial model. This means the Tribunal may ask questions and seek any information necessary to make a decision. It may make inquiries of the participants or of other people, call for documents, question the participants and even call witnesses.

The inquisitorial nature of the Tribunal articulated in section 181 of the Act also provides that the Tribunal is not bound by rules of evidence and is expected to conduct each proceeding:

as expeditiously and with as little formality and technicality as the requirements of this Act, the regulations and rules and a proper consideration of the matters before it permit.

The inquisitorial and informal nature of hearings gives the Tribunal the scope and flexibility to adopt solution-focused techniques. For example, a participant may wish to talk about issues that may not be strictly related to the matters determined by the Tribunal. While the Tribunal must guard against ‘issue creep’, it should be flexible enough to be open to discussing issues that hearing participants consider important.

The inquisitorial and informal nature of the Tribunal allows some scope to raise these issues so that a participant’s primary concerns are respectfully acknowledged and, if not able to be addressed formally in a hearing, agreement reached about how these issues will be addressed after a hearing. This enhances the ability of consumers and their support people to engage in hearings and to feel their voices are being heard – an essential feature of the solution-focused approach.

The example of Dany's hearing below shows how a constructive discussion of broader concerns can be an important part of a solution-focused hearing.

'Dany'

During Dany's hearing, her family members raised their dissatisfaction with communication between them and the treating team. They also had concerns about specific aspects of Dany's care. Family members felt Dany's experience on the ward had been unnecessarily traumatic as she had been restrained and sedated even after they had shared with the treating team that Dany had been a victim of abuse and was not able to trust strangers. Dany's family also provided information about how to encourage Dany's adherence to treatment.

During the hearing, Dany's doctor also had an opportunity to respond to specific medication and nursing issues raised by Dany's family. He also provided his perspective on some of the complexities around Dany's health and treatment during her most recent admission.

The Tribunal encouraged the treating team and Dany's family and friends to resolve the communication issues. They supported the idea of establishing a single point of communication to avoid further difficulties and support Dany in her recovery. As part of this discussion, 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 recommendation. The Tribunal noted that Dany had accepted and received treatment for many years without the need for a Treatment Order and expressed the hope that, once her mental health was more stable, Dany would again be able to be treated on a voluntary basis.

3.5 Embedding recovery-oriented practice

This section explores the difference between clinical and personal recovery as they relate to the work of the Tribunal.

3.5.1 Difference between clinical and personal recovery

The Act promotes 'recovery-oriented practice',⁵¹ but what is meant by this term? The term 'recovery' is used in a range of ways, making its meaning somewhat ambiguous.⁵² For example, the term can be used to refer to *clinical recovery*, which is 'primarily defined by mental health professionals and pertains to a reduction or cessation of symptoms and 'restoring social functioning'.⁵³ In contrast, *personal recovery* 'is defined by the person and refers to an ongoing holistic process of personal growth, healing and self-determination'.⁵⁴ In a widely used definition of personal recovery, Anthony describes it as:

*... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*⁵⁵

The term 'recovery-oriented practice' generally refers to personal recovery. For example, the former Victorian Department of Health's *Framework for recovery-oriented practice* (2011) describes the term recovery as 'an overarching philosophy that encompasses notions of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement'.⁵⁶

Importantly, the Victorian Supreme Court has specifically recognised and endorsed this broader concept of recovery:

*In the mental health context, 'recovery' is a term of art. It reflects a contemporary understanding of 'health' that is broad – one that requires the social and personal circumstances of the person to be considered and one that is not focused exclusively on preventing and curing illness or disease as such. It emphasises the significance of respecting and promoting patient's self-determination over time and ensuring that patients avoid dependence and institutionalisation.*⁵⁷

Justice Bell went on to quote the Minister for Mental Health in the second reading speech relating to the Mental Health Bill:

Recovery is often described as a journey rather than an outcome. The term 'recovery' in the mental health context does not necessarily mean that the person no longer has mental illness or is no longer experiencing any symptoms of mental illness. Instead, recovery in mental health encompasses the often-fluctuating nature of mental illness where some people will not have a recurrence of mental illness, others will have some further episodes and some will experience repeated episodes over time.

*Recovery is about maximising individual choice, autonomy, opportunity and well-being during a person's life and accordingly is a self-defined process that is highly individual.*⁵⁸

3.5.2 Recovery-oriented practice

The former Department of Health's *Framework for recovery-oriented practice* (2011) describes recovery-oriented practice as:

The aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness (Shepherd, Boardman & Slade 2008). Thus a recovery-oriented approach represents a movement away from a primarily biomedical view of mental illness to a holistic approach to wellbeing that builds on individual strengths (Davidson 2008).

The term 'recovery-oriented practice' describes this approach to mental health care, which encompasses principles of self-determination and personalised care. Recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting and self-management. Typically, literature on recovery-oriented practice promotes a coaching or partnership between people accessing mental health services and mental health professionals, whereby people with lived experience are considered experts on their lives and experiences while mental health professionals are considered experts on available treatment services.

For the purposes of the 2011 framework, recovery-oriented practice is understood as encapsulating mental healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves a holistic approach that addresses a range of factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships
- supports people's social inclusion, community participation and citizenship.⁵⁹

The Royal Commission has noted that recovery-oriented practices are a 'critical aspect of enabling people to live full and contributing lives'.⁶⁰

3.5.3 Recovery-oriented practice and the Tribunal

While the Tribunal is not making treatment decisions, the principles of recovery-oriented practice are relevant to many aspects of the Tribunal's role, as the following examples illustrate:

- Recovery-oriented principles are relevant to the Tribunal's consideration of risk – for example, where a person may not regard the presence of some symptoms as a risk to their health, particularly where there are side-effects of treatment to consider. The 2011 *Framework for recovery-oriented practice* specifically addresses the issue of risk and states that 'given that a recovery approach involves promoting people's choice, agency and self-management, a degree of risk tolerance ... becomes necessary'.⁶¹ Part of this involves 'working within the inherent tension between encouraging 'positive risk taking' and promoting safety'.
- One aspect of a recovery-oriented approach to risk is to appreciate that consumers may relapse for a range of reasons, not least as part of the pattern of their mental illness. In other words, relapse is possible irrespective of whether a consumer is a patient. The place of risk in decision making under the Act including the concept of the 'dignity of risk', one of the principles of the Act, is explored in [Chapter 10](#).
- The Tribunal's function under the Act to determine the duration of an Order must take into account that the end point of compulsory treatment within a recovery-oriented model focused on personal recovery may be considerably earlier than clinical recovery or a complete clinical resolution of symptoms.

With solution-focused hearings aiming to promote not only autonomy, but also greater collaboration amongst hearing participants, Tribunal processes can promote (or at least not detract from) the potential to realise recovery outcomes.

3.6 Recognition of the central role of carers and support people

The Act promotes recognition of and respect for the central role of carers and support people more generally. One obvious way it aims to do this is through the nominated person mechanism. However, most patients still don't have a nominated person and it cannot be assumed that a nominated person will always be the primary carer.

To fulfil its obligations under the Act, and because it appreciates the significant contribution that nominated persons, carers and other support people can make to hearings, the Tribunal has undertaken significant work to encourage and facilitate their participation in hearings. Participation of family, friends, carers and support people is covered in more detail in [Chapter 9](#).

3.7 Constructive engagement with mental health services and other support providers

As part of adopting a solution-focused approach, the Tribunal seeks to foster hearings that provide an opportunity for constructive discussions between the patient (and their carers and support networks) and their treating team and other support services where possible and appropriate. A potential outcome is that if a Treatment Order is made, there is a clearer pathway to voluntary treatment. The case study of 'Jack' below provides an example of how the Tribunal facilitated a constructive discussion between the consumer, his treating team and his accommodation service.

'Jack'

'Jack' lived in youth accommodation designed for young people who wish to study but who are homeless or at risk of homelessness. Jack had virtually no contact with his family. Jack had some history of engagement with mental health services before his admission.

Jack's treating team was seeking an Order for three months on the basis that Jack did not accept he had suffered a relapse of his mental illness, noting that Jack believed he suffered from anxiety for which he did not need medication. At the time of the hearing, Jack was receiving depot and oral medication.

Jack attended the hearing with the manager and two case managers from his accommodation service. Jack told the Tribunal 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 said the medication obstructed his work and study.

The staff from Jack's accommodation said that Jack needed support. It was acknowledged that previously there had been little or no co-ordination between Jack's treating team and the accommodation service. There was discussion about Jack's lack of understanding of his mental illness and early warning signs. There was also an occupational therapist's report indicating that Jack did not respond to coercion and valued his autonomy and independence.

During the hearing there was discussion about the importance of co-ordination between the mental health team and the team at the accommodation service. The Tribunal was told that Jack was able and well-regarded and he responded well when he was in an environment of his own choosing. 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 as 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 share their perspective and listen to the perspective of others so they could be involved in developing and engaging with the outcome of Jack's hearing.

3.7.1 Case management

Case management can be an integral part of ensuring that hearings are participatory and solution focused, particularly if there are a number of service-providers involved in a person's treatment.

Case management may involve a range of strategies including:

- allocating additional time for the hearing
- contacting relevant parties and agencies well in advance of the hearing to ensure their availability to participate in the hearing
- requesting all reports and submissions earlier than usual to maximise preparation time
- requesting that such reports or submissions provide answers to specific questions
- preparing a case management briefing note for the division outlining the background, legal history and any statements of reasons or reports from previous Tribunal divisions.

The case study about 'Asha' below from the Tribunal's submission to the Royal Commission illustrates how case management can contribute to ensuring the right information and participants attend hearings to maximise the opportunity to facilitate discussion with the consumer, their treating team and other relevant persons and agencies about working towards a less restrictive treatment, and ultimately towards the consumer's recovery and full participation in community life.

'Asha'⁶²

Asha had been an inpatient in a secure setting for several years and had two Tribunal hearings over six months. After the first hearing, the Tribunal wrote to the parties providing a detailed outline of the information it would require for the second hearing. The Tribunal proposed that the 'receiving service' – the service which would be responsible for treating Asha when she left the current service – should join as a party at the second hearing. The receiving service was notified of this, and was required to provide certain information. The Tribunal stressed this information could be provided in collaboration with the current service.

At the subsequent hearing, the current and receiving services presented a comprehensive treatment plan and discharge strategy developed in consultation with Asha, her family and her Victoria Legal Aid legal representative. The plan was creative, it was long-term and had considered a number of contingencies and issues. The expectation was that transition from the current to the receiving service could happen over four to six weeks.

The transition plan was the product of the combined efforts of the current and receiving services, which worked in close collaboration with Asha, her family and lawyer. The parties acknowledged the Tribunal's case management approach used for these hearings played an important role in advancing progress in what was an exceptionally complicated set of circumstances.

³⁹ Victorian Parliamentary Debates, Legislative Assembly, 20/02/2014, 470, 477.

⁴⁰ PBU & NJE v Mental Health Tribunal [2018] VSC 564, [67].

⁴¹ Ibid, [66].

⁴² Royal Commission into the Victorian Mental Health System, June 2019, *Formal submission from the Victorian Mental Health Tribunal*, 8.

⁴³ Victorian Parliamentary Debates, Legislative Assembly, 20/02/2014, 470, 471.

⁴⁴ PBU & NJE v Mental Health Tribunal [2018] VSC 564, [252].

⁴⁵ Royal Commission into Victoria's Mental Health System, *Interim Report*, November 2019, p. 197.

⁴⁶ *Mental Health Act 2014*, s. 70.

⁴⁷ *Mental Health Act 2014*, Division 3 of Part 3.

⁴⁸ Mental Health Act, Division 4 of Part 3.

⁴⁹ Mental Health Act, Division 4 of Part 5.

⁵⁰ See Part 3 of the Tribunal's Annual Report for information about recent and ongoing initiatives.

⁵¹ See Victorian Parliamentary Debates, Legislative Assembly, 20/02/2014, 470, 471 and Department of Health, 2014, *The Mental Health Bill 2014 – An explanatory guide*, State Government of Victoria, Melbourne, p. 8.

⁵² Department of Health, 2011, *Framework for recovery-oriented practice*, State Government of Victoria, Melbourne, p. 2.

⁵³ Ibid. Another publication refers to clinical recovery as 'an idea that has emerged from the expertise of mental health professionals, and involves getting rid of symptoms, restoring social functioning, and in other ways 'getting back to normal': Mike Slade, '100 ways to support recovery', 2nd edition, *Rethink Mental Illness*, 2013.

⁵⁴ Ibid.

⁵⁵ Anthony, WA 1993, 'Recovery from mental illness: the guiding vision of the mental health system in the 1990s', *Innovations and Research* 1993; 2:17-24 as quoted in Slade, above n 43, 8. This passage was also cited in the Royal Commission Interim Report, above n *, 90.

⁵⁶ Department of Health, 2011, above n 42, 2.

⁵⁷ PBU & NJE v Mental Health Tribunal [2018] VSC 564, [103].

⁵⁸ Ibid.

⁵⁹ Department of Health, 2011, above n 42, 2.

⁶⁰ Royal Commission, Interim Report, 90.

⁶¹ Department of Health, 2011, above n 42, 3.

⁶² Royal Commission submission, above n 42, 24, with minor variations.

PART 2 PRACTICAL TECHNIQUES TO PROMOTE SOLUTION-FOCUSED HEARINGS

Chapter 4 Practical communication skills

- High-level practical communication skills are essential to facilitate solution-focused hearings.
- The core principles of effective communication include turn-taking – particularly creating space for participants to speak – connecting, mutual influencing, co-creating outcomes, commitment to the person and to the message and self-monitoring (being aware of the effect of your communication on others).
- Members can promote effective and respectful dialogue through: open questions; the use of techniques such as paraphrasing to clarify what has been said or to demonstrate they have been listening; supporting (acknowledging and identifying with a person’s situation); and giving positive feedback.
- Body language and speech – particularly clear, kind, accessible and recovery-oriented language – are very important for effective communication.

The single biggest problem with communication is the illusion it has taken place. (George Bernard Shaw)⁶³

According to speech pathologist, criminologist and courage facilitator, Rosalie Martin, we sometimes think that because we feel we have said something clearly, this means we have successfully communicated. But the message needs to have been received by the other person for communication to have taken place. It takes openness and willingness to reflect on who our communication partners are and to consider how can we shape the message to assist them to understand.⁶⁴

The language of the legal and medical professions are not widely-shared systems of meaning. This language can be difficult for others to understand. We need to find ways to translate our symbols into a simple system that can be accessed by others.⁶⁵

Communication is a vital component of a solution-focused approach and the basis of supported decision making and effective participation in hearings. Effective and kind communication makes an enormous difference to the experience that consumers have of their hearing. Developing practical techniques to improve communication is particularly critical in the context of the Tribunal, where hearing participants can face significant challenges and barriers in sharing their perspectives and articulating their concerns and wishes.

4.1 Factors affecting communication

A number of factors can affect the ability of a participant to communicate, not least their mental illness. The current mental state of a participant, including the effects of psychosis, dementia or depression, may impact their ability to communicate in a hearing. For example, delusions may give rise to the potential for misunderstanding and suspicion. Individuals with depression may speak slowly, and with difficulty. People with dementia have impaired cognition and they may confabulate to hide their loss of memory.

Moreover, participants are often highly stressed and anxious about their situation and what is going to happen in a hearing. King states that 'anxiety can compromise motivation and cognitive functioning, adversely affecting memory, the ability to express one's thoughts and feelings clearly and language skills'.⁶⁶

Personality factors or other individual differences can also affect communication. For instance, some people are naturally shy and do not speak much even in supportive social environments, much less in Tribunal hearings.

Cultural differences, traditions and mores, as well as a lack of English-language skills, can also affect a participant's ability to participate and the ability of Tribunal members to understand what is being said. The Tribunal or others may not fully appreciate the participant's cultural background or they misconstrue their cultural norms. This might lead to an inappropriate conclusion about the reasons for a patient's denial of mental illness or symptoms of that illness, or for their failure to make eye contact during a hearing. It is worth noting that a participant may deny their mental illness for cultural reasons. Some cultures may ascribe a different meaning to what is happening to a person or to a particular set of circumstances.

People whose first language is English who are experiencing severe mental illness may also have low-level language ability. This means they have difficulties processing complex vocabulary and sentence structures. They often also have limited working memory, making it difficult to retain information long enough to process and understand it. Add to this the emotional dysregulation which can be a feature of mental illness and the stress of a hearing, and a person's ability to follow and participate in the hearing may be very limited.⁶⁷

Carney et al confirm that the ability of consumers 'to participate effectively in tribunal hearings depends on their capacity at the time, as well as their understanding of the tribunal's function, their emotional state and the opportunity they are given to contribute'.⁶⁸ Sometimes, a participant is acutely unwell at the time of the hearing, which obviously negatively impacts their ability to engage and participate effectively. This is demonstrated in the following two anecdotes by participants in mental health review hearings.

'I didn't have my wits about me. I didn't know what the consequences were or what the ramifications were. I'm not critical of it but I was in no fit state to object to the thing.' (Victorian consumer, v3)⁶⁹

'Sometimes they can be so acutely unwell that they present themselves quite well initially, and then under the tension of the hearing, or the length of the hearing, they can be their own undoing as well. They can start to say things that make it

very clear to the magistrate or the tribunal that they're incredibly unwell. It's a very hard process for them. And it's a big thing. Sometimes they crumble under the pressure.' (NSW social worker, h2)⁷⁰

As the work of the Tribunal inherently involves interacting with individuals who may face multiple impediments to effective communication, members need to employ diverse communication skills and strategies to reduce these barriers.

To understand some of the issues that patients may be facing, members and other readers are encouraged to consult King's Bench Book for detailed and useful information on substance abuse, mental health and family violence.

4.2 Overview of communication techniques

The use of appropriate forms of speech (including language selection), body language and listening skills are important competencies in the solution-focused hearings palette.⁷¹ These skills can help members to engage in a dialogue with participants and gain a clearer understanding of their thoughts, feelings and motivations in relation to their mental health and underlying and related issues.

The communication techniques described in this Guide are very well-established and members and other hearing participants will be familiar with them. However, this Guide is an opportunity to consider and explore these skills and techniques in the specific context of the Tribunal and to link them with a solution-focused approach.

These techniques also help to harness the problem-solving skills of participants to address the issues confronting them.⁷² In other words, solution-focused communication skills promote effective and positive communication between members and all hearing participants – including consumers, the treating team, advocates, carers and other support people, as well as family members.

While the research of Carney et al is now a decade old and recent surveys conducted by the Tribunal indicate considerable progress has been made,⁷³ one theme that continues to be relevant today is that effective communication with participants is vital. The findings of Carney et al emphasise the importance of interactive communication in which the consumer is the central focus:

For consumers, communication is not merely about the 'order' but also the 'style' of discussion, such as whether more fluid exchanges between parties may convey a sense that consumers are being excluded, rather than promoting informality and inclusion in the process. There were comments that, instead of the communication being restricted to rather mechanical questioning by the tribunal, usually the legal member, there could be more interaction or discussion between other members and the consumer, or between the treating team and the consumer. While obviously desirable, care needs to be taken to keep the focus on the consumer.⁷⁴

[...]

Overall, the account that the study team received from consumers, carers and advocates was the importance of communication and collaboration between the consumer and those in power, including the tribunal and the treating teams.

This section of the Guide contains practical tips for how members can use speech, body language and language selection to promote a solution-focused approach to hearings. The next section 4.3 discusses some core principles behind solution-focused communication skills: turn-taking, connecting, mutual influencing, co-creating outcomes, commitment to the person and the message and self-monitoring. The following sections examine strategies that can promote effective and respectful dialogue ([section 4.4](#)), other ways of communication with participants ([section 4.5](#)) and speech and the use of language in hearings ([section 4.6](#)).

4.3 Core principles of effective communication

This section explores core principles of facilitating effective communication which Tribunal members can apply in hearings.

4.3.1 Turn-taking, creating space, encouragement and support

As King states, turn-taking involves giving participants the ‘space, encouragement and support to communicate what they wish to say about their thoughts, feelings, behaviour and what is happening in their lives’.⁷⁵ It is about demonstrating visibly that members and participants can learn from each other.

In turn-taking, it is particularly important to create the space for participants to speak. For instance, some participants may not respond immediately to questions or opportunities to speak. By quickly ‘filling the void’ with their own comments, members can potentially miss the opportunity of hearing from some participants.

Another part of creating space, encouragement and support is asking a person how you might help them feel most comfortable and connected to the conversation and to encourage feedback – for example by asking them to let you know if you are going too fast, not making sense or they need a break. Maintaining a quiet and kind tone is also important, along with regularly thanking participants for their contribution.⁷⁶

At the start of a hearing, or when discussing difficult topics during a hearing or delivering a decision, it can be helpful to ask a consumer how they are feeling and what supports they have around them. The start of the hearing is often when participants are most nervous. Following the grounding hierarchy set out in the box below can provide key information to help participants feel more grounded and stable.⁷⁷

Grounding hierarchy – the four Ps

Place – talking about where you are. Here we are in this place – you’re on the phone etc.

People – who is in the room with you – establish and name the people who are present.

Purpose – explain the reason why you’re gathered.

Process – explain how it will work / what will happen.

It can also be helpful for members to acknowledge they may not always get the tone right and they are open to the consumer letting them know if this is the case. For example:

*'I'm concerned that I might not say something as well as I want to. I want to say these things well but please tell me if I've said something or asked you something in a way that makes you feel bad.'*⁷⁸

4.3.2 Connecting

Connecting means there should be a 'connection between what each party to the dialogue says and what the other party has said'.⁷⁹ In other words, connecting is about members demonstrating they are listening to what a participant has said (and where appropriate, asking follow-up questions to clarify issues or develop the conversation to gain a better understanding of what is being said).⁸⁰

Connecting is also about recognising that the narrative of consumers can be affected by their mental illness and general confusion or nervousness, and acknowledging and accommodating the difficulties that consumers may experience in communicating at the hearing. It is increasingly common practice across the Tribunal for the community member to start the discussion with the consumer, with a particular emphasis on gaining a clearer picture of their broader social circumstances to provide a context for discussion about mental health and treatment issues. This is not an inflexible approach. For instance, where it appears a consumer is affected by medication and/or symptoms of an illness, psychiatrist and registered medical practitioner members will have particular experience and expertise and may be best placed to take the lead in the discussion.

4.3.3 Mutual influencing

King describes the key elements of mutual influencing as:⁸¹

- participants and members 'are open to the ideas and suggestions of the other'
- members are 'vigilant to ensure that preconceptions and stereotypes concerning the participant do not influence how communication from a participant is evaluated'
- members recognise that in a hearing there will be multiple sources of 'creative ideas as to how problems can be addressed'.

4.3.4 Co-creating outcomes

Closely related to the concept of mutual influencing is the idea of co-creating outcomes. Co-creating outcomes is about ensuring that participants have a 'genuine role in determining what is to result from the dialogue with the [Tribunal]'.⁸²

4.3.5 Commitment to the person and to the message and self-monitoring

Commitment to the message refers to 'knowing what one is talking about, caring about what one says and being sincere'.⁸³ Commitment to the person involves taking time instead of rushing, being willing to listen carefully (instead of doing all the

talking), using language that makes sense to the other person and being open to change after hearing the other person's ideas.⁸⁴

Self-monitoring is about being aware of the effect of your verbal as well as your non-verbal communication on others.⁸⁵ However, it is important to strike an appropriate balance between seeing how others react to one's approach (and assessing whether it needs to be modified) and too much self-monitoring, which can distract members from communicating and listening effectively.

Commitment to the message and self-monitoring are consistent with Rosalie Martin's work on clear, kind and accessible communication. Martin has stated that to be 'heard' is about giving time for consumers to speak. However, Martin also emphasises that being heard is as much about the manner of our words and how we speak them as the words themselves (although choice of language is also important – see more on this below). We may think the other person is the problem for not understanding our message, rather than us not conveying it well.

The poet Mary Oliver said 'to pay attention – this is our endless and proper work'. Paying attention to our communication is a key strategy which members can apply to 'cut through' the struggle that communication can be for many participants. Competent communicators have the privilege of choice in their communication – something many hearing participants don't have. It is up to members to find ways to convey meaning and ensure they have truly communicated their message. Some practical guidance for doing this is included in the following sections.⁸⁶

4.4 Strategies to promote effective and respectful dialogue

A judicial officer can use questions, statements, requests, single words or non-verbal prompts to promote dialogue with participants.

The judicial officer should take care in framing questions and other responses to avoid anti-therapeutic effects.⁸⁷ (King's Bench Book)

Members can use various techniques to promote a constructive dialogue with participants in hearings. Several of these are outlined below.

4.4.1 Use of questions

Questions are a means of 'directing, facilitating or controlling the flow of communication'.⁸⁸ It is important for members to be sensitive about the effect that questions can have on their rapport with a participant in a hearing.

Ideally, questions should make a participant 'comfortable and open to sharing [their] thoughts, feeling and experiences'.⁸⁹ The emphasis should be less on what is said than on promoting the flow of communication.

General guidelines for questions include: asking only one question at a time; asking short questions in simple words; and giving the other person enough time to respond.⁹⁰ These are explored below.

As a general rule, when asking questions it can help to use the person's name (while being careful not to over-use it).⁹¹

Leading questions have limited use in hearings

The form of the question is important. Leading questions that suggest the desired response should have limited use in hearings. For example, 'you have problems with your treatment team, don't you?'. Leading questions are not the best means of promoting open communication with a participant (although they can be used to confirm the evidence of participants or to demonstrate that you are listening).

Open questions are ideal

'Open' questions, particularly questions which use the words 'what' and 'how' are ideal because they give a participant the opportunity to explain matters of concern to them.

The start of a hearing can be a particularly good time to ask open questions about a participant's wellbeing and what has been happening in their lives, as it enables further questioning to be put in a broader context and demonstrates interest in the participant's overall wellbeing. In general, asking questions and making comments with kind affect (such as a kind gaze and gentle tone of voice) and thanking the participant regularly for their answers is important.⁹²

One technique is to ask questions about the individual's broader circumstances that are referred to in the report.

'How are you, Brian? What has been happening since your last hearing? How have you been coping?'

'I see that you moved house recently, Sharon. How is the new accommodation working out for you?'

Open questions tend to elicit longer answers and are good for developing an open dialogue, which elicits more detail and helps you better understand the other person's opinion.⁹³

Exercise caution with 'why' questions

It is best to be cautious with 'why' questions. 'Why' questions can make a participant feel 'defensive and less open to communication as they can be perceived as being a demand for explanation'.⁹⁴

The use of 'how' and 'what' questions can be a less confronting way of eliciting information and, if used with appropriate tone of voice and body language, can demonstrate a caring interest in a participant's wellbeing.

Compare:

'Why did you stop your medication? or 'Why didn't you keep your appointment with your doctor?'

– with –

'I see that you stopped your medication. / This report mentions you missed an appointment with your doctor. What happened there? / How did that come about?'

Checking for understanding

Apart from slowing the pace of speech and pausing for a participant to respond, checking for understanding is a useful technique to make sure consumers have understood a Tribunal member's question or statement. This should not be in the form of asking a participant 'do you understand the question?', because this is a closed question which research has shown a person will generally reply 'yes' to whether they have understood or not. Instead, it is preferable to ask a person to repeat back what you have said or to ask what it means to them. Another technique is to repeat the question and flag the key points. 'Sign posting' what is particularly important helps consumers with low level language skills to focus their attention.

Don't ask:

- 'Do you understand?'
- 'Got that?'
- 'All okay?'

Ask instead:

- 'Can you tell me in your own words what I've said?'
- 'I'll say that again. This is important.'
- 'What does that mean to you? What did you notice about that?'

Further tips for questioning participants

Further useful tips from King's Bench Book include:⁹⁵

- deal with each issue in turn rather than jump back and forth between topics (which can be a challenge to a participant's cognitive processes)
- be sensitive as to the nature and number of questions asked: participants should not feel as though they are being 'grilled'
- asking the participant for further information can be an effective way of enhancing communication, although this should not come across as a demand or an order.

4.4.2 Using a single word or phrase and making a statement

Using a single word or phrase can be an effective way to move the dialogue along. The following example is taken from King's Bench Book.⁹⁶

Participant: I used ice on Friday. It wasn't good. I've been thinking about what I need to do.

Magistrate: What do you need to do?

Participant: What I need to do is stop using.

Effective short prompts include 'yes', 'go on', 'okay' and 'uh-huh'. Nodding is a non-verbal prompt.

Making a statement – most commonly in the form of saying that you do not follow what has been said – can get a participant to elaborate without sounding accusatory.

Making a statement such as 'I am not clear what brought about your relapse' is better than a 'why' question such as 'Why did you relapse?' .

4.5 Other ways of communicating with participants

Apart from using questioning techniques such as those described above, paraphrasing, supporting, analysing, advising in an empowering way and judging are all solution-focused techniques members can use in hearings. These techniques are summarised below.

4.5.1 Paraphrasing

Paraphrasing is using your own words to repeat back to someone else what they have said. It is a communication technique that draws on active listening skills (see Chapter 5).⁹⁷

Paraphrasing can be used to clarify what has been said, to demonstrate that you have been listening and care about what a participant thinks and feels. It can help a participant to clarify their thoughts and feelings. However, excessive use of paraphrasing might seem artificial or strained.

Jenny: I started hearing the voices again for a while. But they changed my medication and I feel better now.

Member: So, you're feeling better because you changed medication, is that right?

4.5.2 Supporting

Supporting involves acknowledging and identifying with a person's situation.⁹⁸ It may involve expressing empathy, agreement, praise and reassurance. This technique

recognises that it can be counter-productive to discount a person's situation or how they feel (for example, with statements such as 'It's not that bad' or 'You'll feel better tomorrow') as these responses can stifle dialogue. Similarly, attributing blame is unlikely to make a participant feel motivated to engage with the discussion nor potential next steps.

Li: I felt terrified when four big men came to my door and took me to hospital like I was a criminal.

Member: I can understand why you would find that experience terrifying. Have you had a chance to talk about it with your doctor?

Kevin: I've started working part-time and it's going well so far.

Member: Well done. What type of work are you doing?

The importance of positive feedback and the drawbacks of negative feedback

Research by Carney et al highlights the important role positive feedback can play in hearings, particularly in giving the decision.⁹⁹ Positive feedback may be particularly useful when the Tribunal has determined that compulsory treatment is no longer needed. Rosalie Martin also emphasises the importance of positive feedback and compliments accompanied with a kind, expectant look and / or tone. Thanking a participant frequently for their honesty and participation is an important part of establishing and maintaining rapport.¹⁰⁰

As a corollary, as Carney et al state, 'when the decision is accompanied by negative rather than positive treatment it was reportedly very damaging to the consumer's sense of the fairness of the system and might well have negative therapeutic effects'.¹⁰¹

4.5.3 Analysing or interpreting: caution advised

Analysing or interpreting is an important function of judicial officers, but care should be exercised in using this technique with a participant in hearings, particularly with regard to their personal situation and problems.¹⁰² As King points out:

*A judicial officer's analysis of the personal situation of a participant may be wrong – due to insufficient or inaccurate material before the court or a misunderstanding of that material. Even if it is correct, it may arouse a participant's defensiveness as it could be construed as the judicial officer asserting she [sic] is a better authority on the participant's situation than the participant.*¹⁰³

If attempting an interpretation, the motive should only be to assist others in resolving an issue. This would be consistent with promoting the self-determination, personal goal setting and self-management of consumers, which are important goals of recovery-oriented practice.

In the context of Tribunal hearings, a scenario that might invite interpretation is when there is open, perhaps even hostile, disagreement between participants. In these situations:

- 'it is better to offer analysis or interpretation in tentative rather than absolute terms ('Perhaps the reason is...')
- the analysis should have a reasonable chance of being correct
- the analysis should only be offered when the person is likely to be open to it
- the motive to offer the analysis should only be to assist ... others in resolving their problems'.¹⁰⁴

4.5.4 Advising: caution advised

As with analysing, caution should be exercised if advising participants. This is because a key aim of a solution-focused approach (and of the new legislation) is to empower participants to make their own decisions with support.¹⁰⁵

As King points out, continual advice to participants about how to resolve problems does not support their self-sufficiency. A further problem is that a member's advice may be considered more 'authoritative' than the participant's own ideas, which means the participant may blame the member if the advice does not 'work'.

If giving advice, it is best to do so tentatively rather than on an absolute basis. This indirect approach places the onus on the participant to talk through the pros and cons and reach a consensus; it is a less risky and more effective technique.

Member: What if you were to ...? What do you think about that?

Finally, if a member gives advice, it is important the advice is accurate, that the participant is open to accepting it and that the advice is delivered in a caring manner.¹⁰⁶

4.6 Speech and use of language

King reminds us that we need to be constantly sensitive to the possible effects of language selection.¹⁰⁷ The Bench Book contains some general rules of thumb, which are summarised below. Rosalie Martin's work also provides useful suggestions to communicate effectively with careful language so that everyone can understand and participate in the hearing.

However, these and other techniques outlined are not 'rules' to be applied rigidly in every case. When communicating with participants in hearings, it remains important to rely on general communication skills, intuition and common sense.

4.6.1 The importance of language

According to the Recovery Oriented Language Guide:

Appropriate language is a vital component in communicating a sense of self-determination, because feeling powerless can be overwhelming, especially when decisions seem to be or are in the hands of others.¹⁰⁸

The words that members use in hearings can send a powerful message about whether they value, believe in and respect participants – even when consumers themselves do not attend hearings. For this reason, language needs to be respectful, non-judgmental, clear and understandable, free of jargon; consistent with body language and ‘sincere in carrying a sense of commitment, hope and presenting the potential for opportunity’.¹⁰⁹

The *Recovery Oriented Language Guide* (attached as an Appendix to this Guide) provides some do’s and don’ts and examples of out-dated and worn-out words as well as examples of language of acceptance, hope, respect and uniqueness. These guidelines are important to remember when addressing the treating team (even if the consumer is not there) as well as the consumer. They are also relevant to statements of reasons.

As the *Recovery Oriented Language Guide* states:

If worn out words are used to describe people’s attempts to reclaim some shred of power while receiving services in a system that may try to control them, then important opportunities to support a person’s recovery will be lost.¹¹⁰

Compare:

‘How long have you been mentally ill / schizophrenic?’

With:

‘How long have you lived with a mental health condition? / Can you remember when you were first told you had schizophrenia?’ (Acknowledging the consumer is not their condition or diagnosis)

Or

‘So to summarise, would you say Kylie is non-compliant with her medication and has no insight into her illness?’

With:

‘To summarise, is it fair to say that Kylie feels her medication isn’t helping her and that she disagrees with the diagnosis schizophrenia?’

Avoid technical, legal and medical language

Keep language simple and direct (but not so overtly that it comes across as condescending). The *Recovery Oriented Language Guide* advises:

Don't use jargon, or unfamiliar language

*Don't use specialist or medical language unless you accompany it with plain English explanations.*¹¹¹

This approach recognises the fact that solution-focused hearings are focused on consumers playing an active and significant role in hearings.

Rosalie Martin advises to simplify language as much as possible, such as by using the participant's vocabulary. It is important to use very plain English (and avoid academic and long words). Use single clauses, the active voice and avoid conjunctions. This reduces the mental effort involved in linguistic processing for lower-level language users.¹¹²

Compare:

'If you weren't subject to a compulsory Treatment Order, what do you think the consequences of that would be in terms of your treatment?'

With:

'Let's make a picture. We don't make an Order today. What would you do?'

Research conducted by Carney et al indicates that even in 2011, board and tribunal members were generally 'aware of the need for plain English, and tailoring language to suit the consumer',¹¹³ as the following quotations illustrate.

'For someone with a mental disability you need to keep it very simple, it is about short sentences. It is not about a lot of explanation about the law, it's about being clear about who we are, what our role is, what the role of the Board is and gathering the evidence in that total way, so that it does not get on a train and the train carries the information away, and the person is left beside or behind.'
(Victorian legal member, m3)¹¹⁴

'What I try to do is to get some sense of the person I'm talking to and how they would normally interact with other people and then work on those sorts of levels. We certainly are in an environment where there is lots of jargon around so trying to de-jargonise, particularly medical matters, is really important. Making sure people really do understand as best they can what's going on is important. And that varies enormously.' ([former] Victorian MHRB President, m5)¹¹⁵

As is clear from the second quotation, one of the greatest challenges in Tribunal hearings is to monitor and manage the use of jargon by clinical participants.

Hearings deal with difficult and complex issues and they can be an overwhelming experience. One useful technique is to normalise the complexity of the process as a shared experience.

'This is complicated – let's understand it together.'

'Your situation is complicated. Thank you for taking the time to help me understand the parts I didn't understand.'¹¹⁶

4.6.2 Avoid qualifying positive statements with 'but'

If you are making a positive statement (for example, encouraging a participant) try to avoid using a qualifier that detracts from it.

'It is great you stayed off drugs since your last appearance, but you missed an appointment with your counsellor.'¹¹⁷

In this example, staying off drugs is significant: the achievement and the missed appointment are two separate matters that should be dealt with separately.

4.6.3 Exercise caution in using 'you'

Using the personal pronoun 'you,' particularly in questions, can seem to attribute responsibility or blame and may place participants on the defensive or make them feel intimidated.¹¹⁸ The example below shows a more neutral and open way of asking the question without using 'you'.

Problematic: 'How come you didn't attend appointments with your case manager last month?'

Better: 'We've been told about some missed appointments with your case manager. What happened there?'

This example does not carry any implication that the participant was at fault and leaves open other possibilities. At the same time, it places on the participant the responsibility to explain the missed appointment.

On the other hand, sometimes using 'you' is important, particularly when seeking input from a participant or their involvement in decision making.

Acceptable use of ‘you’:

‘How do you think we should deal with this matter?’

‘What action are you taking/wanting to take to maintain your health / avoid future disputes with your neighbour?’

‘If we decide to make an Order, how long do you think would be reasonable?’

Use of ‘you’ in questions to the treating team also needs to be carefully considered.

‘We need some more information about the treatment and support X will be given so as to decide how long an Order should last’ is clearly preferable to ‘You haven’t provided enough information about treatment to enable us to decide the appropriate duration of an Order’.

However a ‘you question’ along the following lines could contribute valuable and constructive details regarding next steps: ‘What are some of the changes you would be looking for as an indication an Order may no longer be needed?’

4.6.4 Use of ‘we’ and humour

Using the inclusive collective pronoun ‘we’ can promote a feeling of collaboration and the sense that participants are not alone but supported.¹¹⁹

‘How do you think we should deal with this issue?’ ‘What do you think we should do?’

Using humour is a normal part of human interaction and can sometimes be appropriate to lighten the atmosphere in hearings. A participant may sometimes be humorous while engaging with the Tribunal – such as speaking about themselves in a self-deprecating way – as a means of dealing with their difficult situation. However, King reminds us that care should be taken not to use humour at the expense of participants. In addition, it is important to remember that a participant’s use of humour or particular language is not automatically intended as a licence for everyone else to do the same.

Rosalie Martin agrees that humour can be a salve but only if you have an established rapport with the participant. Members should take care to use only small moments of humour when it can enrich the connection between the Tribunal and the participant. Humour is appropriate only where it is empathic and shares a difficulty or creates a reciprocal moment.¹²⁰

⁶³ Cited in Rosalie Martin, presentation to Tribunal members on 4 September 2020.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ King Bench Book, above n 1, p. 123.

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- ⁶⁷ Martin, above n 63.
- ⁶⁸ Carney et al, above n 4, p. 186.
- ⁶⁹ Ibid.
- ⁷⁰ Ibid.
- ⁷¹ King Bench Book, above n 1, p. 121.
- ⁷² Ibid.
- ⁷³ Ibid.
- ⁷⁴ Carney et al, above n 4, pp.181-182.
- ⁷⁵ King Bench Book, above n 1, p. 122.
- ⁷⁶ Martin, above n 63.
- ⁷⁷ Ibid.
- ⁷⁸ Ibid.
- ⁷⁹ King Bench Book, above n 1, p. 122.
- ⁸⁰ Ibid.
- ⁸¹ Ibid.
- ⁸² Ibid.
- ⁸³ Ibid, pp. 122-123, drawing on R B Adler and R F Proctor, 2007, *Looking out, Looking In*, Thomson, 12th edition, p. 32.
- ⁸⁴ Ibid, p. 123.
- ⁸⁵ Ibid.
- ⁸⁶ Martin, above n 63.
- ⁸⁷ King Bench Book, above n 1, p. 125.
- ⁸⁸ Ibid. This section generally is drawn from King Bench Book, above n 1.
- ⁸⁹ Ibid.
- ⁹⁰ Angela Dixon, 'Effective Questioning for Eliciting Information from Witnesses in Tribunal hearings, , *Council of Australasian Tribunals (COAT) conference 'Mind Over Matters,'* 28 August 2015, p. 9.
- ⁹¹ Martin, above n 63.
- ⁹² Ibid.
- ⁹³ King Bench Book, above n 1, p. 13.
- ⁹⁴ Ibid, p. 126.
- ⁹⁵ Ibid.
- ⁹⁶ Ibid, p. 127.
- ⁹⁷ This section is drawn from King Bench Book, above n 1, pp. 127-128.
- ⁹⁸ This section is drawn from King Bench Book, above n 1, p. 128.
- ⁹⁹ Carney et al, above n 4, p. 237.
- ¹⁰⁰ Martin, above n 63.
- ¹⁰¹ Carney et al, above n 4, p. 237.
- ¹⁰² This section is drawn from King Bench Book, above n 1, pp. 128-129.
- ¹⁰³ Ibid, p. 129.
- ¹⁰⁴ This section is quoted from King Bench Book, above n 1, p. 129, drawing on Adler and Proctor, above n 62, p. 258 (punctuation altered).
- ¹⁰⁵ This section is drawn from King Bench Book, above n 1, p. 129.
- ¹⁰⁶ King also refers to 'judging' on p. 130. However, as he states, it should generally be used to determine whether a person is admitted to or terminated from a program or whether sanctions should be applied: this does not seem relevant to the MHT context.
- ¹⁰⁷ This paragraph is drawn from King Bench Book, above n 1, pp. 131-132.
- ¹⁰⁸ Recovery Oriented Language Guide, above n 5, p. 4.
- ¹⁰⁹ Ibid, p. 5.
- ¹¹⁰ Ibid, p. 10.
- ¹¹¹ Recovery Oriented Language Guide, above n 5, p. 6.
- ¹¹² Martin, above n 63.
- ¹¹³ Carney et al, above n 4, p. 178.
- ¹¹⁴ Ibid.
- ¹¹⁵ Ibid.
- ¹¹⁶ Martin, above n 63.
- ¹¹⁷ King Bench Book, above n 1, p. 131.
- ¹¹⁸ This section is drawn from King Bench Book, above n 1, p. 132.

¹¹⁹ Ibid.

¹²⁰ Martin, above n 63.

Chapter 5 Practical listening skills

- The satisfaction of participants with hearings is improved when they feel the Tribunal has taken their views into account and treated them with respect.
- Effective listening skills are crucial to achieving this outcome and help build rapport and promote self-determination.
- The potential therapeutic effect of listening can be impaired by:
 - failing to pay attention
 - having expectations about what is going to be said and not listening to what is actually being said and
 - misinterpreting what is being said.
- Non-verbal body language (including facial expressions) reflects a listener's level of engagement.
- The concept of active listening includes not only verbal and non-verbal signs that members are attentive and understand what is being said but also that members are alert to the feelings being conveyed and demonstrate genuine interest and empathy.

An ability to listen effectively is the basis of good communication and interpersonal skills generally and an important aspect of solution-focused hearing techniques.¹²¹

5.1 The positive power of listening

Research shows the satisfaction of participants with the legal process is increased when they feel the court or tribunal has 'taken their story into account in reaching a decision and treated them with respect'.¹²² Good listening skills and being able to demonstrate to participants that their views and concerns have been heard are critical to achieving this outcome.

Feedback from family, carers and nominated persons in the most recent Tribunal Hearing Experience survey highlighted how Tribunal members taking the time to listen to participants and understand their concerns contributes to a positive hearing experience.¹²³

'The members of the Tribunal were very good with my mum, listening to her, adjusting to her behaviour (walking around the desk due to anxiety) and ... not saying anything about it, or making an issue of it.'

'My dad and myself felt respected by the Tribunal as they listened to our opinions and took them into consideration. The Tribunal stayed at least an extra 30 minutes at the end of their day to accommodate a second hearing my mum required at short notice. This communicated to me and my father that my mum's wellbeing was paramount.'

Very good at introducing themselves, listened to what I had to say and I agreed with everything [they] had to say.'

Active listening techniques can help members to engage in therapeutic communication with participants and promote their trust in the Tribunal. It is important to recognise that 'some forms of behaviour and some environments inhibit the listening process and should be avoided'.¹²⁴

Listening is also the basis for building rapport with participants in hearings. By listening and developing rapport, members can promote the recovery of participants by helping them clarify their thoughts and feelings and to solve problems, as well as by treating them as individuals whose ideas, views and concerns are worthy of respect and consideration.¹²⁵

While listening can have different purposes, relational or empathetic listening is perhaps the most relevant to solution-focused hearings.¹²⁶ Members engage in empathetic listening when asking participants to explain the nature of their concerns and issues, how they arose and how they would prefer to address them.

This type of listening can also promote the self-determination of participants in that members seek their views on the making of Orders (or other issues) and take those views into account in reaching their decision. However, the importance of empathetic listening does not override the evaluative function of listening, which is to critically examine the content of what is being said.

For information on the theory of the cognitive, affective and behavioural factors involved in listening and the stages of listening (pre-interaction, interaction and post-interaction), members are encouraged to read Chapter 6 of the Bench Book.

5.2 Ways that listening can be impaired

The potential therapeutic effect of listening can be impaired in a number of ways:¹²⁷

- *failing to pay attention* – for example, being distracted due to fatigue, boredom, the mannerisms or appearance of participants, a busy list, tuning out due to a view that what is being said is irrelevant
- *having expectations about what is going to be said* and not listening to what is actually being said or twisting what is said according to preconceptions about the participant (a form of prejudging)

- *not receiving the message communicated due to misinterpreting what is said* due to the beliefs, attitudes to life and life experience of members (a form of prejudging)
- *tribunal environment or processes not conducive to listening* – too much noise, too many cases, too much distance between the participants
- blocking tactics (see below)
- interruption (see below)
- *multi-tasking* – doing too many tasks at once: for example, reviewing the file and taking notes while listening can divide a member’s attention (see the next section 5.2.1).

5.2.1 Note-taking and reading files during the hearing

Reading the files and note-taking during hearings is important, particularly as participants may later request a statement of reasons for the decision. On the other hand, note-taking can potentially detract from interaction with participants (either actual or perceived). King offers this advice:

*Having one’s attention on a court file for too long may create the impression that the judicial officer is not giving the participant his full attention. It could be that note-taking is limited to periods when a participant finishes talking or it is done in stages with the agreement of the participant.*¹²⁸

Strategies for note-taking in hearings

Several strategies can be adopted to achieve a balance between reading the files and note-taking and giving participants a member’s full attention.

Explain the reason for taking notes is because what the participant is saying is valuable.

Ask whether the participant minds if you take notes while they are speaking or if there may be pauses to take notes.¹²⁹

Ensure not all three members are looking down and taking notes or perusing the files at the same time.

5.3 Non-verbal body language

According to the Recovery Oriented Language Guide:

*Research has shown that communication is only 7% verbal and 93% non-verbal. The non-verbal component is made up of body language (55%) and tone of voice (38%).*¹³⁰

Non-verbal body language can be important in showing that a listener is receptive to what is being said.¹³¹ Body language reflects a listener’s level of engagement: if someone is really listening, their body language will communicate their interest. If

they are merely 'going through the motions', that will also be communicated. Examples of positive and negative body language are given below.

Negative body language

- Leaning back on the chair or pushing it away or looking away too often can send the message that a member is uninterested or is creating distance from the participant.
- Crossing arms can appear defensive and suggests that members are closed to the message being conveyed.
- Engaging in other activities suggests a lack of interest.

Positive body language

- Leaning slightly forward shows that a member is receptive and interested.
- Turning one's chair to directly face the speaker suggests receptivity.
- Looking in the direction that the participant is speaking promotes a sense of openness to receive information from the participant.
- Kind, encouraging facial expression and positive gestures such as nodding can convey a more authentic and enlivened engagement (even if the hearing is being conducted on teleconference!)¹³²

Negative body language can give participants the impression their matter is not important. Two other aspects of non-verbal body language – making eye contact and facial expressions – are discussed below.

5.3.1 Eye contact: exercise caution

In Western culture, looking a speaker in the eyes may indicate attentiveness, interest and respect. However, other cultures perceive this differently. For example, in the cultures of Aboriginal and Torres Strait Islander peoples, looking someone directly in the eyes may convey a lack of respect.¹³³ For this reason, members need to be sensitive to cultural mores while promoting respect.

Even when a participant comes from a Western culture, there may be cases where too much direct eye contact may hinder rapport. If a participant seems ashamed, embarrassed, scared, overawed or have low self-esteem, care may be required not to make too much eye-contact.

5.3.2 Facial expressions

Like non-verbal body language, facial expressions can reflect the feelings of a listener and either encourage or hinder communication.¹³⁴ For example, a kind,

relaxed facial expression conveys receptivity and may encourage a participant to speak.

However, it is important that facial expressions are genuine (for example, they should change with the mood of the conversation). Otherwise, the message of interest in a participant can be undermined. If gestures and facial expressions are done without genuine respect for the participant, they can come across as false.¹³⁵

5.4 Blocking and interrupting: *caution needed*

Blocking is when 'a listener says things that stop the speaker from continuing to speak or from speaking about a preferred topic'.¹³⁶

It is clear from the research conducted by Carney et al and others that blocking or interrupting can give a participant the impression that members are not really listening or taking account of their evidence. Carney et al recount the experience of a consumer with the former Board:

But they didn't seem to take very much notice of what I said.

What made you think that?

It was just their attitude. I wasn't very happy at all. I felt I wasn't allowed to talk. If I did talk it was just that they were just listening and that was all.

They weren't hearing what you were saying? Is that what you mean?

Yes.

Was that something to do with their body language?

It was just the way that he kept saying 'yes, yes, yes, yes' to me. Sort of interrupting me when I was speaking. Yes we've heard that before from the person who advocated for me. Yet they asked me to speak.¹³⁷ (Victorian consumer, v17).

Blocking and interrupting participants may sometimes be necessary to get through the scheduled hearings for the day. However, these techniques can detract from communication with a participant as they may indicate a lack of interest in the participants has to say. It is important to be aware of the potential negative effects of these techniques and to use them carefully. Psychiatrist and registered medical practitioner members will have particular skills in focusing, diverting and directing a participant.

5.4.1 Exercise caution with blocking comments

Sometimes blocking is unintentional (in other words, without the intention to divert the speaker or terminate the conversation.) Examples include: 'You'll be alright' or 'Don't worry about it'. Using these sorts of phrases before a participant has finished speaking may suggest their feelings are unimportant.

Other blocking techniques include: rejecting a participant’s topic; responding to only part of what is said; shifting the topic; referring the speaker to someone else; deferring the conversation; and pre-empting communication (for instance: ‘There’s no time to talk about that now’).

Some alternatives to blocking comments are provided below.

| Blocking comment | Possible alternative |
|--|--|
| <p>‘You’ll be alright.’</p> <p>‘Don’t worry about that.’</p> | <p>Thank the person for talking about the topic, which is clearly important to them. Ask them to now focus on another important matter (a different topic).</p> |
| <p>‘There’s no time to talk about that now.’</p> | <p>Be transparent about the limits of a hearing. Explain that the Tribunal needs to ensure that the participant’s hearing is finalised and needs to consider the other people who have a hearing that day.</p> |
| <p>‘That’s not relevant to our decision.’</p> | <p>Acknowledge that the issue is not only important, but that it’s – from the perspective of the participant – related to their treatment. Clarify that the Tribunal cannot resolve the issue. Seek an undertaking from the treating team regarding when and how the issue will be followed up after the hearing and/or provide advice regarding the correct avenue for following up the issue (for example, the Mental Health Complaints Commissioner).</p> |

5.4.2 Interrupt respectfully when necessary

Interrupting a participant can break their line of thought and inhibit them from communicating what they are thinking and feeling. The effect can be more pronounced for participants who are already uncomfortable with communicating about sensitive issues.

One option to avoid interrupting a participant is to take a quick note of questions and then raise them once they have finished speaking. On the other hand, sometimes interruption is necessary. As King notes, ‘if a participant engages in a protracted monologue then the judicial officer will need to intervene’.¹³⁸ A respectful way to do this is suggested below.

The solution-focused judicial approach occurs in the context of a dynamic and empathetic interaction between judicial officer and participant. A courteous way of interrupting and getting the dialogue back on track would be to say to the participant:

'You've made several points. I want to make sure I've understood them'.¹³⁹

Another technique is to be upfront about the need to interrupt, even frequently. For example:

'I am sorry to interrupt, but I wanted to check...'

'I am really sorry to interrupt again ...'

Participants in hearings may sometimes raise issues that may be best dealt with by other professionals. If possible, members should take a reasonable time to listen to participants' concerns rather than cut them short. As King notes:

*Ideally the judicial officer should hear the participant in full, acknowledge what she has said, note the participant's concerns and then ask the participant whether she has considered raising the matter with another professional.*¹⁴⁰

5.5 Active listening

According to King:

*In active listening, the listener provides verbal and non-verbal clues that the listener is attentive, that the information being conveyed is being received, understood and processed, that the listener is alert to feelings that are being conveyed by the speaker and that the listener feels and demonstrates empathy for the speaker. It means laying 'aside your own views and values in order to enter another's world without prejudice'.*¹⁴¹

For effective communication to occur, including active listening, the atmosphere must be 'non-threatening, non-moralising and non-evaluative'.¹⁴² Only under these conditions will participants feel comfortable and free to be open.

5.5.1 Aspects of active listening

Active listening involves members:¹⁴³

- showing a genuine interest in participants
- listening for the whole message being conveyed – including a participant's life experiences, thoughts, feelings and behaviour – as these all give valuable insight into the participant
- taking in the whole message by listening to the tone of voice, manner of delivery and body language (for example, posture, facial expressions and hand movements)

- listening for the strengths, weaknesses and problems of a participant
- being aware of any internal filters through which they are interpreting a participant's message (such as a member's own perceptions, beliefs, thoughts, feelings or past experiences), which will help prevent these filters distorting what a participant is saying
- outwardly demonstrating they are listening (see the techniques described earlier in this chapter)
- checking if a participant needs silence or has finished speaking (for example, by asking if they wish to say anything further or have more time to speak)
- be comfortable with silence – don't rephrase in the 'gaps' as this adds to the processing load¹⁴⁴
- invite feedback – ask a participant if you are going too fast, saying too much, not making sense or whether they need a break.¹⁴⁵

5.5.2 Adopting a flexible approach to listening and communication

The techniques described in this and in Chapter 4 can promote a more empathetic, therapeutic interaction with participants in hearings. However, King emphasises that communication and empathetic listening should not be 'conducted according to a fixed formula' and that members should adapt their approach according to the particular situation.¹⁴⁶ As King observes:

Interpersonal communication varies according to the circumstances and the personalities, backgrounds and needs of the people involved. People may well vary in what they value in empathetic communication. It is therefore important that judicial officers be sensitive to the individual situation of the participant and what he [sic] is saying and to the uniqueness of the interaction between the bench and each participant.¹⁴⁷

¹²¹ King Bench Book, above n 1, p. 136.

¹²² Ibid, p. 135.

¹²³ *Mental Health Tribunal, Hearing Experience Survey: Report*, Health and Community Consulting Group Pty Ltd, February 2020, p. 15.

¹²⁴ King Bench Book, above n 1, p. 135.

¹²⁵ Ibid, p. 139.

¹²⁶ The rest of this section is drawn from King Bench Book, above n 1, pp. 136-138.

¹²⁷ This section is drawn from King Bench Book, above n 1, pp. 141-142.

¹²⁸ Ibid, p. 139. Also see pp. 142-143.

¹²⁹ The first two points are based on King Bench Book, above n 1, pp. 142-143.

¹³⁰ Recovery Oriented Language Guide, above n 5, p. 4.

¹³¹ This section and the examples are drawn from King Bench Book, above n 1, pp. 143-144.

¹³² Martin, above n 63.

¹³³ This section is drawn from King Bench Book, above n 1, p. 144.

¹³⁴ Ibid.

¹³⁵ Martin, above n 63.

¹³⁶ Apart from the separately footnoted materials from Carney et al, above n 4, the paragraphs on blocking and interruption are drawn from King Bench Book, above n 1, pp. 145-146.

¹³⁷ Carney et al, above n 4, p. 184.

¹³⁸ Ibid, p. 146.

¹³⁹ Ibid.

¹⁴⁰ King Bench Book, above n 1, p. 145.

¹⁴¹ Ibid, p. 146, drawing on C B Rogers and R E Farson, 1987, 'Active Listening,' in Newman, Danziger and Cohen (eds), *Communication in Business Today*, Houghton Mifflin, pp. 589, 591. This section generally is drawn from King Bench Book, above n 1, pp. 147-148.

¹⁴² Ibid, p. 147.

¹⁴³ Drawn from King Bench Book, above n 1, pp. 148-149.

¹⁴⁴ Martin, above n 63.

¹⁴⁵ Ibid.

¹⁴⁶ King Bench Book, above n 1, p. 149.

¹⁴⁷ Ibid.

Chapter 6 Processes and strategies in solution-focused hearings

- Practical communication techniques and strategies that members can use in solution-focused hearings include:
 - demonstrating positive (high but not unrealistic) expectations of consumers which can enhance self-efficacy and the ability to problem solve
 - supporting a consumer's self-efficacy by referring to times when they were managing better
 - facilitating dialogue and exploring possibilities and options for the future
 - facilitating and supporting people's motivation to engage in and maintain behavioural change
 - motivational interviewing which involves exploring the views of participants about change and why it should happen rather than imposing the views of others on them.
- Where appropriate and authentic, praise can be used to recognise achievements and to support the motivation and self-efficacy of participants.
- While they are rewarding, solution-focused hearings can also be stressful and may lead to burnout, compassion fatigue and vicarious trauma. Tips for dealing with the stresses of hearings and who to contact for further support are provided.

King's Bench Book contains processes and strategies that members can use in hearings. Basic solution-focused principles such as voice, validation, respect and promoting self-determination underlie many of the strategies. However, they are not formulas to be applied rigidly. The use of any particular strategy will depend on the circumstances of the case.

6.1 Having positive expectations of participants

Having positive expectations of participants can be a useful tool in solution-focused hearings. King's Bench Book points to evidence that 'the expectation that those in authority have in relation to those under their jurisdiction affects the latter's performance'.¹⁴⁸ High, but not unrealistic, expectations of participants – and the use of strategies that demonstrate these expectations – may enhance a participant's self-efficacy (see the next section 6.2) and ability to address issues, such as not adhering with medication or taking illicit drugs, which are contributing to the decision to make a compulsory Treatment Order.

Having positive (but not unrealistic) expectations of a participant means using strategies that display confidence in their abilities, such as adopting active listening techniques, including a participant in the decision-making process and supporting

their self-efficacy. This approach also reflects the fundamental principle of the Act: the presumption of capacity on the part of consumers.

On the other hand, it is important to be sensitive to the personal situation of a participant at the time of their hearing. If a participant has recently experienced a sudden traumatic event, it may be 'insensitive and burdensome' to communicate high expectations of them.¹⁴⁹ This could include a person recovering from a recent episode of psychosis or mania which might have involved uncharacteristic behaviour of a harmful or acutely embarrassing nature.

6.2 Supporting self-efficacy

Self-efficacy is the 'belief in one's ability to function competently'.¹⁵⁰ Research indicates that self-efficacy is 'significantly related to motivation and performance levels'.¹⁵¹ People with self-efficacy are likely to meet challenges head on, persisting where those with low self-efficacy may give up. In taking a solution-focused approach to hearings, members should promote self-efficacy in participants as much as possible.

One technique to support self-efficacy is to refer to factors and times when a participant was handling things better.¹⁵² For example, referring to times when they have not been on a Treatment Order, not admitted to hospital or had stable accommodation.

6.3 Using persuasion, facilitating dialogue and exploring possibilities

The Bench Book notes that one way that a solution-focused approach can promote self-efficacy in participants is to engage in persuasion.¹⁵³ However, 'persuasion' is a problematic term in the context of the Act with its emphasis on individual autonomy and supporting people to make their own decisions about their treatment and determine their individual path to recovery.

Even in other contexts, persuasion is a technique in the solution-focused palette that should be used sparingly. As King observes, consistently trying to persuade a participant to agree with a course of action that is against their expressed views 'is inconsistent with an approach that seeks to promote self-determination and may retard the participant's self-efficacy'.¹⁵⁴ (It is also rarely effective or acceptable to an individual who has been made a patient under the Act.) King advises that judicial officers 'should therefore use persuasion only when needed and in a manner sensitive to issues of self-determination and self-efficacy'.¹⁵⁵

However, persuasion in a more limited sense of facilitating dialogue and exploring possibilities and options for the future may be an effective technique. Ways of engaging in persuasion in solution-focused hearings include:

- inviting participants in hearings to put forward options and potential ways to resolve differences and encouraging understanding of each other's concerns
- identifying obstacles and resistance and drawing out and highlighting the insights of participants into their problems.

These methods of engagement require members to be open to persuasion themselves (including by the participant) concerning the decisions they make. As King observes:

*Participants often have keen insight into their problems and what they need to do and what resources they need in so doing. The solution they have in mind may be more appropriate than other options or be something that can be done along with other options. A judicial officer being open to persuasion in this context affords the participant self-determination and respect – as well as other aspects of procedural justice. It also demonstrates the court's trust in the participant.*¹⁵⁶

While not strictly persuasion, explaining the decision to participants in plain, clear language is also important, particularly where the decision is different from what participants (whether the consumer or the treating team) may have wanted or expected. This equips consumers with information that may assist them to understand the Tribunal's reasoning, to decide whether to request a statement of reasons, and, if unhappy with the decision, to decide whether they wish to have it reconsidered by the Tribunal, or the Victorian Civil and Administrative Tribunal (VCAT) and / or request a statement of reasons.

6.4 Motivational interviewing

Motivational interviewing is a method of facilitating and supporting people's motivation to engage in and maintain behavioural change.¹⁵⁷ It has particular relevance in improving engagement with treatment, as well as substance use problems. It is often used where a person is ambivalent about change. Essentially, motivational interviewing:

*... aims to facilitate people to assume responsibility for initiating and continuing with the change process. It endeavours to elicit talk about change from people and have them elucidate their reasons for why change should happen instead of imposing upon them the reasons why others think they should change.*¹⁵⁸

According to King, the technique can be used even in short interactions, making it a possibility in Tribunal hearings. At the very least, it is useful for members to have some awareness of motivational interviewing processes so they can explain their place in treatment planning.

The five main principles of motivational interviewing – express empathy, develop discrepancy, avoid argument, roll with resistance and promote self-efficacy – are summarised in the following sections. For more detail, members and other interested readers are encouraged to consult Chapter 7 of King's Bench Book.

6.4.1 Express empathy

Expressing empathy requires active listening skills in that it requires 'reflecting back key aspects of what a participant has said' and acknowledging the feelings of the person.¹⁵⁹ It also requires placing oneself in a participant's situation and endeavouring to perceive the situation from their point of view.

6.4.2 Develop discrepancy

Developing discrepancy involves highlighting the inconsistencies between a participant's goals and their behaviour, with the aim of helping the participant to think about the possibility of change and to consider the different options for change.

6.4.3 Avoid argument

If a participant is ambivalent about change, engaging them in argument is unlikely to be productive as it 'may provoke defensiveness and lead to a situation where the person is less open to change'.¹⁶⁰

6.4.4 Roll with resistance

Resistance is regarded as a natural part of the change process. It lies at the heart of change. Resistance can be due to change being presented too forcefully. Meeting resistance with coercion or paternalism is likely to promote further resistance. Bear in mind that a cause of resistance may be that the person feels they have no control over the situation and is reacting to assert their autonomy.

Potential responses to resistance include:

- *Reflect back to the person their thoughts or doubts* – often listening to a person empathetically can allow them to clarify those thoughts and may enable them to arrive at their own solution.
- Reframe the situation by acknowledging what the participant has said, but then offer a fresh interpretation of the facts.
- *Agree 'with a twist'* – listen to and acknowledge what the person says (reflecting what they think and feel) but then 'reframe the situation with a view to influencing the person's thoughts in the direction of change'.¹⁶¹

6.4.5 Promote self-efficacy

This principle refers to supporting a participant's belief in the possibility of change and recognises that the person is an important source of change. As indicated in [section 6.2](#), promoting self-efficacy is a key goal of the solution-focused approach to hearings.

6.5 The use of praise

Where appropriate, praise can be used to recognise achievements and to support motivation and promote self-efficacy.¹⁶² However, it is important that a participant knows they deserve praise, otherwise they may view it as gratuitous. In other words, praise should be authentic.

Before praising a participant, it can be useful to ask them to describe what happened and how they achieved a goal. This helps the person to reflect on the skills they used and allows members to praise the method as well as the outcome.

Examples of praise from King's Bench Book are provided below.

'Your rehabilitation plan is comprehensive. It shows [...] careful planning and problem-solving ability on your part.'

'Congratulations on your new job[.] You thought about what you wanted, prepared the application carefully and went to the interview well prepared.'¹⁶³

6.6 Personal challenges of solution-focused hearings

King's Bench Book outlines some of the personal challenges facing members in adopting a solution-focused approach.¹⁶⁴

One challenge is that, while rewarding, a solution-focused approach can be stressful. Heightened levels of stress can lead to burnout, compassion fatigue and vicarious trauma. As King observes:

*Judging in a therapeutic manner requires the judicial officer to maintain independence and impartiality and to undertake a facilitative role in court, assisting the parties to reach a resolution of their problems in a more therapeutic manner. That may involve parties addressing painful underlying issues. As therapeutic judging means that the judicial officer is sensitive to the feelings of the parties and takes a caring, empathetic approach, it follows that the judicial officer will be more exposed to trauma and suffering expressed by the parties than judging in the traditional manner with distance and remove.*¹⁶⁵

It is also important to acknowledge that the often limited and unpredictable amount of time available in hearings can be a challenge to implementing a solution-focused approach. On a busy day, members may feel under pressure to stay focused and 'get on with it'. Members frequently need to balance the interests of the person whose hearing is underway with the interests of those waiting for their hearing to start. There is no 'magic' solution to this, but experienced members have found it works well if they explain the Tribunal does not have unlimited time for the hearing and there are other patients with hearings scheduled after theirs. Specifically referring to other people waiting for their hearings can help a participant to appreciate the personal impact on others if their hearing runs over time and demonstrates that the Tribunal has confidence in and expectations of them in helping to manage the hearing.

Other causes of stress include high workloads, coping with legislative change and adapting to new technology.

For this reason, it is important that Tribunal members have access to adequate training and professional development, as well as opportunities for participation in peer reflection and support. It is also important that Tribunal members maintain an 'ethic of care' towards themselves. King imparts the following advice:

*To protect against the stress involved in such work it is important that judicial officers exercise an ethic of care towards themselves and maintain proper balance in their own lives – attending to positive activities and attitudes that promote their physical and psychological wellbeing and enjoyment of life...*¹⁶⁶

Other ways of dealing with the stresses of solution-focused hearings include:

- taking a few minutes at the end of each hearing day to debrief with other members on the division
- being available to discuss particularly difficult hearings with colleagues in the days after the hearing
- letting the President, Deputy President or senior members know about particularly challenging hearings so that they can provide support and advice
- accessing the Tribunal's Member and Employee Assistance Program (MEAP) – instructions for how to do this are available on the extranet.

¹⁴⁸ King Bench Book, above n 1, p. 162. This section generally is based on King Bench Book, pp. 162-164.

¹⁴⁹ Ibid p. 164.

¹⁵⁰ Ibid. This section generally is drawn from King Bench Book, above n 1, p. 164.

¹⁵¹ Ibid.

¹⁵² Ibid. See discussion of persuasion, p. 166.

¹⁵³ Ibid, p. 166. On persuasion, see also pp. 172-174.

¹⁵⁴ Ibid, p. 174.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid, p. 172.

¹⁵⁷ This section on motivational interviewing is based on King Bench Book, above n 1, pp. 174-177.

¹⁵⁸ Ibid, p. 175.

¹⁵⁹ Ibid, p. 176.

¹⁶⁰ Ibid.

¹⁶¹ Ibid, p. 177.

¹⁶² Ibid, p. 179. This section generally is based on King Bench Book, above n 1, pp. 179-180.

¹⁶³ Ibid, p. 180.

¹⁶⁴ This section is based on King Bench Book, above n 1, pp. 203-207.

¹⁶⁵ Ibid, p. 205.

¹⁶⁶ Ibid, p. 207.

PART 3 RESPONDING TO THE NEEDS OF PARTICULAR CONSUMERS

Chapter 7 Solution-focused hearings for young people

- Important factors to consider when conducting hearings involving young people include:
 - read the materials carefully in advance so as to reduce the need to ask sensitive questions adequately covered in the materials
 - give a brief preamble about how the hearing will progress (even if they have been told previously) to help the young person calm down at the beginning of the hearing
 - use clear, simple and age-appropriate language to explain what the Tribunal will consider and throughout the hearing
 - ‘check in’ with the young person regularly during the hearing
 - speak directly with the young person rather than their parent or carer
 - use a conversational rather than inquisitorial tone
 - ask open questions at the beginning of the hearing about the young person’s life and interests
 - ask about their hopes and dreams for the future and steps forward rather than ‘goals’ which can make young people feel judged when they can’t list concrete objectives
 - contain your curiosity – avoid asking about sensitive issues that are not relevant and are potentially highly distressing
 - have mainly one member responsible for the discussion which can reduce the young person’s sense they are being ‘interrogated’
 - have the member with the most rapport with the young person deliver the decision and highlight any achievements and encouragement.

This Chapter focuses on how the Tribunal can improve the experience of young people who are the subject of Tribunal hearings. The case studies and consumer vignettes come from consultation during the development of this Chapter.¹⁶⁷

It is particularly important for Tribunal members to be mindful of the issues relating to young people. On average young people only make up just over one per cent of hearings so¹⁶⁸ Tribunal members may have contact with a young person at a hearing only a few times a year.

7.1 Practices and strategies in hearings for young people

This section outlines practices and strategies that can be adopted in hearings for young people in the three main phases of the hearing process:

- preparing for a hearing
- conducting the hearing
- concluding the hearing and delivering the decision.

7.1.1 Preparing for a hearing

Before arriving

To help reduce anticipatory stress and anxiety for a young person and their support persons, the mental health service will have been advised to list the matter as the first hearing of the day if possible to minimise the waiting time. The experience of 'Billy' below demonstrates why this is important.

'Billy'

'I thought my Tribunal hearing was going to be in the morning, but it didn't end up happening until the afternoon. I was so anxious and nervous because I didn't know when it would happen; I didn't know if I would be waiting for an hour or two hours. I was just waiting and waiting. It would have been better if the hearing happened first thing in the morning so that I knew what to expect.'¹⁶⁹

The physical environment

When the Tribunal arrives at the hearing venue, members should assess the physical environment to ensure it is as welcoming and non-threatening as possible. While many venues have their limitations, clinical teams at CAMHS and youth services have been working with the Tribunal regarding the physical layout of their hearing rooms. It remains the case that some are still far from ideal. For example, the young person might be seated in a formal configuration across from the panel of three members at a wide table. The Tribunal has rightfully and necessarily been concerned for the safety of members during hearings. However, this should not be a barrier to creating a feeling of comfort and safety for the young person.

Creating a more informal setting is desirable, such as by sitting in a semi-circle, provided it is still clear who the Tribunal members are and they are obviously separate to and independent of the mental health service.¹⁷⁰ In addition, 'a table may not be strictly necessary in the hearing room. If it were necessary, a round table would be better'.¹⁷¹ One consumer commented: 'no desks / people sitting behind tables like you're being faced with an interview panel'.¹⁷² A familiar, [quiet and comfortable] environment is preferred so that consumers and families feel as safe as possible.¹⁷³ Tissues and water should be available.¹⁷⁴

Tribunal preparation

Before a hearing it is important there is adequate time for Tribunal preparation and discussion of how to most effectively and sensitively conduct the hearing given what

is known from the hearing reports and the medical records about the specific circumstances of the young person.¹⁷⁵

Complexities that might arise in any Tribunal hearing may be especially acute or distressing in the case of young people and, when known in advance, require pre-hearing planning. This may reduce the need to ask questions already adequately covered in the material.¹⁷⁶ Volatile family relationships may mean a young person is currently unable to live at home or their situation, including accommodation, may be tenuous. Exploring these matters may be necessary but needs to be planned and circumspect. The Tribunal should consider who might be the most appropriate member to lead the general discussion and questioning, including if, and how, any sensitive issues might be addressed. There should be a strategy planned and articulated to alleviate any distress that is evident during the hearing. 'Well prepared and informed members ... will contribute to reducing the stress of a hearing.'¹⁷⁷

Anticipatory anxiety

In spite of many efforts to make Tribunal hearings as informal as possible in the circumstances, young people and other participants still often experience Tribunal hearings as a formal and anxiety-provoking process.¹⁷⁸ There can be disparity between what the Tribunal states about itself (that it is informal, solution-focused) and the reality of the hearing experience for participants (that it is very formal, even at times, adversarial).¹⁷⁹ In light of this, it is imperative to put in place some strategies to reduce anxiety and to mitigate an overly formal atmosphere, particularly for hearings involving young people.

As a first step, it can be good for one of the Tribunal members to introduce themselves to the young person before the hearing (on the ward or in the clinic) and to explain the hearing process. Victoria Legal Aid commented they:

*... have had positive experiences with [Tribunal] members introducing themselves on an informal basis prior to the hearing to reassure the young person and confirm that all relevant information has been received. We encourage this practice to continue.*¹⁸⁰

This may be an opportunity to give a verbal explanation to the young person and their family or support people about how and why the Tribunal hearing is happening as they may not have read or understood the written information provided.

Given how difficult it can be for young people to articulate their feelings, they could also be given the opportunity to write down what they feel.¹⁸¹ They could read this out or it could be given to the Tribunal to read themselves.

In addition to this, the member might spend a few minutes checking that the right people are there to support them. At least one member of the treating team whom the young person trusts should be there. This would go a long way to putting the young person at ease, promoting their sense of safety and encouraging them to have confidence to actively participate in the hearing.¹⁸²

Young people can be 'more sensitive to family relationships [due to] their still evolving independence and can be quite ambivalent of the involvement of key adults in any way'.¹⁸³ Mental health services should be aware of this information and have taken 'additional steps to encourage and arrange for families, carers, guardians and those closest to the young person to attend'¹⁸⁴ if appropriate.

7.1.2 Conducting the hearing

All Tribunal hearings are meant to be informal. Notwithstanding the need to address issues of procedural fairness and legislative accuracy, the participation of a young person can be encouraged by efforts to make the hearing less formal than one involving an adult consumer.

Managing anxiety at the hearing

Carney et al found that many patients do not experience hearings as positive or helpful and may feel the system is weighted against them.¹⁸⁵ Added to the feelings of trepidation for most consumers, young people may have the extra burden of not really understanding what the process is all about and feeling powerless and confused.

A brief preamble about how the hearing will progress (even if they have been told previously) can help the young person calm down at the beginning of the hearing.¹⁸⁶

This should be followed by the 'legal preamble which should not be too long or wordy': mental state and education must be clear considerations to avoid anxiety and perhaps 'getting lost in the words'.¹⁸⁷

Young people can feel like they are 'on trial' and are being treated like they have done something wrong. The information in the preamble could include advising that the hearing process 'is as much about reviewing the clinical team's decisions' as it is about making decisions about Treatment Orders.¹⁸⁸

One young person suggested:

*Try to bring a little light heartedness and humour to the situation; it's incredibly intimidating being in a meeting with a group of adults/important people.*¹⁸⁹

The case study of 'Riley' below tells a positive story of a hearing for a young person.

'Riley'

'Before the hearing I felt nervous and scared because having to go to a hearing was a completely new experience for me. It was really helpful having a lawyer there to support me and talk for me in the beginning. Once the lawyer began speaking I felt more comfortable and in the end I was able to speak for myself. Once I warmed up I felt comfortable telling the Tribunal what I thought about being in hospital and about the treatment. I felt like I had an opportunity to say what I felt was important and that the Tribunal listened to me.'¹⁹⁰

Use plain English

Carney et al¹⁹¹ found that Tribunal members are generally aware of the need for plain English and tailoring language to suit the consumer. While the Tribunal always seeks to avoid jargon and technical language, hearings with young people call for even greater vigilance so that language is age-appropriate and discussions and explanations are simple and clear. Tribunal members should also be mindful of any developmental or learning difficulties. It is recommended that they frequently 'check-

in' to ensure the young person and their support people are not overwhelmed by information and are following and understanding the proceedings.

As one young person put it:

*Check in with me regularly to make sure I understand everything so far or if I have any questions. Check in with me along the way to see how I'm going. I might need a smoke break or to take a breather for 2 minutes.*¹⁹²

In the *Recovery Oriented Language Guide*, the Mental Health Coordinating Council notes that swearing and 'bad language' features prominently in the language of many young people and advises:

*Enabling conversation that is accepting of this language is important in establishing rapport with a young person. Some of the expressions used by young people may offend others from different age groups and cultures, nevertheless, it is important to be accepting of contemporary vernacular.*¹⁹³

Effective engagement and rapport

Engaging a young person and their support persons would be the first priority for any Tribunal division. However, young people experiencing mental illness can be 'difficult to engage and can sometimes sit silently and stony faced'.¹⁹⁴ This is better understood as fear, anxiety and powerlessness rather than defiance/obstinacy or difficult behaviour.¹⁹⁵

Given each hearing is different and each person individual, there may be various unforeseen barriers to full participation in the process. For example, regression during the hearing process is quite possible. 'The stresses of illness, psychosocial adversities, learning and or developmental difficulties' and of the hearing itself can all contribute to a young person regressing during the hearing. In other words, a young person may function at a much younger level than one would expect – cognitively, emotionally and / or socially.¹⁹⁶

It is more respectful and effective when Tribunal members speak directly with a young person rather than their parent or carer. Questioning should be conversational rather than inquisitorial and the Tribunal should not appear overly deferential to the treating team, parents and other support people.¹⁹⁷ One consumer explained this issue very succinctly: 'Don't talk about me as if I'm not there'.¹⁹⁸

Whether or not one member should take the lead in engaging a young person will vary according to the physical setting for the hearing, who will be attending and the expertise of the members constituting the Tribunal on the day.¹⁹⁹ As previously stated, it might be appropriate for only one Tribunal member to do most of the talking; and the member with the most rapport being the one to deliver the decision.²⁰⁰ However, this 'should not preclude other members questioning other attendees at the hearing, for example, treating doctors, case managers, family members' and other support people.²⁰¹

One way to establish rapport and trust and enable participation is for the Tribunal to ask more general questions at the start of a hearing about who the young person is, independent of any symptoms of mental illness. This includes questions about 'interests, what the young person has been doing etc',²⁰² before the necessary questions that relate to the treatment criteria in the Act. Questions about mental

illness and treatment are likely to be more acceptable once rapport and trust have been gained (see below).

Addressing sensitive issues

Each Tribunal division should look at strategies for handling any possibly sensitive issues. If a matter is not particularly relevant and potentially highly distressing, there should be no need to address it in a hearing.²⁰³ Questions to young people need to be framed particularly carefully, and questioning should be kept to the minimum needed to cover the relevant issues. Having one member responsible for the discussion with the young person may reduce confusion or a sense on the part of the young person they are being interrogated.

Tribunal members should have awareness that ‘comments made in this setting could have ramifications for the carer when they return home with the young person’.²⁰⁴

The experience of trauma, violence, abuse and family breakdown/dysfunction may be among the factors that have made voluntary or less restrictive treatment untenable. In this context, sometimes the most neutral questions may inadvertently tap into deeply upsetting or embarrassing emotions. The fear of these issues emerging could restrict participation of a young person.

In some circumstances it may be appropriate to give the young person the opportunity to speak to the Tribunal without their family in the room²⁰⁵ or for a member to meet the young person individually if they do not want to attend the hearing.

Other possible issues and sensitivities in a young person’s life may include: drug and alcohol abuse (in their lives or the lives of their support people); poverty; sexuality and sexual activity; loss and homelessness; or a familial history of mental illness. Questions from relatively safe and non-confrontational areas can progress to areas of greater delicacy and intrusion if necessary and appropriate.²⁰⁶

If questioning has led to a young person or one of their support people becoming distressed and emotional, Carney et al suggest acknowledging when a person is upset trying ‘to address these emotions as well as what a person may require, whether it be a break, a glass of water or some other support’.²⁰⁷

Hearing the young person

In most (but not all) hearings, there are people in attendance with opposing views. This complex situation can be overwhelming for the young person at the centre of the issues, whose voice is only one of many and who might feel they are the least powerful person in the room.

In this context, it is important to bear in mind the principle in section 11(1)(c) of the Act, which emphasises the importance of consumers participating in decisions about their treatment:

*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.*²⁰⁸

Accordingly, a central focus must be accorded to the views and preferences of the patient, as well as the people who support them including their nominated person (if there is one identified) and carers.²⁰⁹

In light of this, the Tribunal should ask at the start of a hearing what the young person would like the outcome to be. The Tribunal should let the young person know they will have opportunity to talk about their wishes and to respond to the stated wishes and opinions of others. The case study below of ‘Amir’ tells the story of how a young person can feel like the least important person in the room.

For some young people, their nominated person, a peer support worker or a trusted case manager could be well placed to present their needs and wishes if they feel nervous or unable to otherwise speak independently.²¹⁰

‘Amir’

‘I had only been in Australia for a very short time before I was taken into hospital. My parents wanted to care for me at home but the doctors said that I needed to be in hospital. I wasn’t nervous about the hearing – actually, I felt good about the hearing before it happened because I thought I could raise my concerns about being in hospital and about the medication I was on and perhaps be able to go home. I liked the idea of being able to talk about what was happening and for me and my family and the doctors to make a decision about what should happen together. However, during the hearing I felt like the Tribunal members were mainly listening to the doctors. It would have been better if they listened to me and my family more, instead of just the doctors.’²¹¹

Promoting a recovery focus

The Act embeds a focus on recovery and recovery-orientated practice.²¹² Definitions for ‘clinical’ and ‘personal’ recovery are well articulated previously in this Guide and explain that the term recovery-oriented practice refers to personal recovery, the holistic process of personal growth, self-determination, choice and empowerment, working with the individual’s strengths and building hope.²¹³

The goal of recovery is to progress towards a meaningful and satisfying life and what this means for any particular young person will be subjective, individual and related to their stage of maturity.

It is important for the Tribunal to explore with a young person their recovery goals and ‘support ... encourage [the young person by] ... positively affirming ... achievements provided that these are relevant and appropriate...’²¹⁴

On the other hand, the *Recovery Oriented Language Guide* advises that the idea of being asked to formulate recovery goals ‘can lead [young people] to feel judged, especially when they are unable to list concrete objectives’. Rather than asking them about their goals for the future, it may be better to talk instead ‘about the hopes and dreams young people may have for themselves’.²¹⁵ According to the *Recovery Oriented Language Guide*:

An alternative approach is to refer to ‘steps forward’ rather than ‘goals.’ For example, “what do you think may be some useful steps forward?” or “What are you looking forward to doing (e.g. when you are discharged from hospital,

go home etc.)?” Young people are often figuring out who they are and what they want of life and don’t want to be cornered.²¹⁶

Allowing for an element of risk

As noted in Chapter 3, a recovery-oriented approach involves promoting choice and self-management, even in circumstances where this may involve a degree of risk, and this is reflected in the principles in the Act. The concept of the dignity of risk is explored further in Chapter 11.

In any hearing the Tribunal is required to explore concerns regarding serious deterioration in mental or physical health and the potential for serious harm. In this context, grappling with the implications of dignity of risk needs to consider a range of perspectives including those of the young person, their nominated person (if they have one), carers and the treating team.

Assessment of risk and dignity of risk requires consideration of developmental issues. [It needs to be recognised] that children and adolescents will be much more impulsive than adults because of the immaturity of the developing brain... As well, the young person’s concept of death can be quite different from that of the adult... they may think that death is reversible...or even that they are immortal...²¹⁷

Balancing risk and the provision of optimal treatment is a principle which should drive clinical practice and could be assumed/expected this therefore is an important issue for the treating team. The Tribunal might even explicitly ask the treating team how they see the proposed treatment fitting with a consideration of patient choice and dignity of risk.²¹⁸

Role of families and carers

Family dynamics can be very complex and a hearing can be a difficult and even traumatic event for family members as well as a young person.²¹⁹

In regard to parents, their

...reactions to mental illness in their child can be complicated and at times unhelpful. This should ... be met with some empathy and efforts to assist and support their understanding and importantly their role in their young person’s care.²²⁰

The Act states that the Tribunal needs to consider the views of certain people such as family members and carers²²¹ and so ‘carers may need encouragement to attend and [the] young person may need encouragement to invite their family’.²²² There may be an assumption in some services that the consumer does not want family there, whereas the preferable assumption may be that young people *do* want their family attending. In many cases, family members will be caring for the young person after the Tribunal hearing (or once they are being treated in the community). The family needs the ability to express their feelings about their role, especially if there are safety issues.²²³

Family peer support workers or carer consultants can be used to ‘coach’ the family about the upcoming Tribunal hearing so they feel less anxious, and empower them to advocate for their needs in a respectful context.²²⁴

Unfortunately, as observed by Victoria Legal Aid:

*...the reality for many of the young people we assist is that often they do not have supports they trust and can rely on. In this context, insisting on the participation of family members can operate to inhibit engagement by the young person.*²²⁵

The Tribunal should be mindful in these situations that a young person has the opportunity to receive independent legal advice and that all aspects of procedural fairness are observed. Issues around family, carers and other support people participating in hearings are explored further in Chapter 9.

A duty lawyer's observation

'I assisted a 15-year-old young person with a hearing before the [Mental Health Tribunal]. To everyone's surprise, the young person's father attended the hearing unexpectedly. It was clear from the material contained in the report on compulsory treatment that the family dynamic was a concern. The young person also disclosed in her instructions that she did not feel comfortable returning home.

During the hearing the father was questioned at length about the family environment and his own circumstances before the young person was given an opportunity to speak. Following this, the young person did not feel safe to disclose her concerns about the home environment and did not engage well with the Tribunal. Given the power imbalance, she also did not feel comfortable enough to request that her father leave the room.

In this case it would have been appropriate and ultimately more beneficial for the Tribunal to speak with the young person without her father present for a period during the hearing. This should be initiated by the Tribunal, because in my experience it is common for young people to not feel comfortable enough to request that their parents leave the room. They are also unlikely to openly discuss issues regarding drug use, family violence or an unwillingness to return to the home environment in front of them.'²²⁶

Note taking by Tribunal members

As mentioned in [section 5.2.1](#) of this Guide, excessive note taking and reading files during hearings can be a barrier to building rapport and encouraging participation in any Tribunal hearing. These matters may be a particular issue in hearings involving young people. Accordingly, the purpose of taking notes and how they will be taken should be explained. For example, a division may opt to take notes while participants are speaking or opt to take pauses while Tribunal members take notes during the hearing.

The preferred option is that one Tribunal member is elected to take notes, or that members take notes in turn. This prevents a young person and their support person/s being faced with all three members writing at the same time, losing eye contact with the young person and risking losing rapport and trust.

7.1.3 Concluding the hearing

The Tribunal member who appears to have the most rapport with a young person may be best placed to be the one to deliver the decision.²²⁷ The Tribunal decides whether or not to make an Order and, if so, the category and duration of that Order. Explaining Tribunal decisions can be quite complicated. However, Victoria Legal Aid suggests:

*decisions are better received when the Tribunal acknowledge[s] and articulate[s] the specific views of the young person, explicitly state[s] how these have been considered during their deliberations [and provides] specific reasons [for the decision] in an open and direct way.*²²⁸

A complication and source of confusion for patients of any age is when the Tribunal makes an Inpatient Treatment Order. The Tribunal sets the duration for compulsory treatment (the majority of which may be received in the community) but patients often hear the duration as the amount of time they will actually spend in hospital.

When stating the duration of an Order, the Tribunal should be mindful that a young person may have a different perspective of what is considered short-term and long-term.²²⁹

Carney et al suggest the delivery of a determination is an opportunity to provide a person with a 'clear outline of how their views have been considered'²³⁰ as a way of validating their concerns and opinions. Listening to and considering the views of consumers is integral to solution-focused communication principles. It's important to capture and convey this when explaining the Tribunal's decision.

Accordingly, whether or not the decision was to make an Order or to revoke a current Order, explaining the determination is an opportunity to reflect on the positive gains a young person has made in their journey to recovery so far. As noted above, the Tribunal should positively affirm the young person's achievements provided these are relevant, appropriate and specific and offer encouragement about future progress. The importance of positive feedback as part of the technique of supporting is highlighted earlier in this Guide.

While the discussion cannot be too prescriptive, a young person should leave with a clear picture about 'where to from here'. In other words, if an Order is made, it is preferable for the Tribunal to indicate the support and treatment it will facilitate, and more critically, the steps or changes that will mean an Order becomes unnecessary in the future. Of course, this discussion can only occur at the time of explaining the determination if the issues have been canvassed during the hearing.

If families and support people are not present at the hearing, or not present to hear the outcome, the Tribunal should confirm with the treating team how they will be informed of the decision. This is particularly important where a decision affects where a young person will be living.

7.2 Conducting a hearing with a young person present as a carer or support person for the patient

The Act specifically recognises that young people can be the carer of a family member or friend with a mental illness (section 11(1)(k) and (l)). Patients may also attend hearings with a young person as support for them or as a dependant. This can

give rise to some complexities. Depending on the nature of the issues that may need to be discussed in the hearing, consideration needs to be given to the possibility of any distress or discomfort the young person might experience as a result of the discussion. This needs to be balanced against the possibility the patient may be distressed if their (young) support person or dependent child is not present (which may impact detrimentally on their participation) and also cause distress for the young person or child.

These situations are complex and there is no 'one-size-fits-all' solution. Tribunal divisions need to weigh up the following considerations to decide whether on balance it is appropriate for the young person or child to be present:

- the age of the young person
- their role in the life of the patient
- the possible content of the information that will be presented at the hearing
- the patient's expressed wish about the presence of the young person or child and in particular, how critical it is to their attendance / participation
- the young person's expressed wish about being present at the hearing
- the treating team's view based on their knowledge of the situation and family roles
- approaches to the hearing that might enable the young person or child to be present for most of the discussion but absent when distressing matters are explored.

If it is considered not appropriate or desirable for the young person to attend part or all the hearing, suitable arrangements need to be confirmed about where they will be and who will be with them. The patient, young person and other relevant people all need to be comfortable with this arrangement.

‘Danh’

Danh, a young man in his late teens, lives at home with his parents and other family members. Danh's mother, Kim-Ly, is his primary support and carer. Kim-Ly is also the guardian of her grand-daughter, Lan, who is 18 months old.

It was Danh's first admission to hospital and he had made good progress during the three-week admission supported by Kim-Ly, who had visited Danh almost every day and was engaging in family meetings and psychosocial education with the treating team (with the assistance of an interpreter).

At the hearing, Kim-Ly asked the Tribunal if she could bring Lan into the hearing as the child care arrangements she had made had fallen through. The Tribunal considered it was appropriate to allow the little girl to attend the hearing for the following reasons:

it was Danh 's first hearing and so it was particularly important that Kim-Ly was able to attend, participate and provide Danh with support

the Tribunal did not want to exclude family members who were willingly engaging with the service and were keen to provide support to Danh during his admission and on his return to the community

Lan was an infant and was unlikely to understand the discussion at the hearing given her age and because English was not spoken in the home.

Before the hearing, it was agreed with Kim-Ly that if Lan became disruptive or upset, she would take her outside to allow the hearing to progress without distraction.

During the hearing, Lan was calm and quiet and sat in the lap of her grandmother or uncle. Danh was openly affectionate with Lan and this interaction was important for the Tribunal to observe as part of Danh's overall presentation.

At the conclusion of the hearing, Kim-Ly thanked the Tribunal for helping her to participate in the hearing by allowing her grand-daughter to remain in the room.²³¹

¹⁶⁷ This Chapter was drafted with input from representatives from Orygen Youth Mental Health Services (consumers, family peer support workers and clinicians), the Royal Children's Hospital, and Austin Health – Child & Adolescent Mental Health (who also included consumer feedback) as well as Tribunal members, including members with child and youth mental health expertise and Victoria Legal Aid.

In addition, Tribunal representatives attended a state-wide meeting of the Children and Adolescent Mental Health Services / Child and Youth Mental Health Services (CAMHS / CYMHS) Clinical Leaders' Group to discuss the issues identified and spoke with clinicians, managers and directors of CAMHS and youth services formally at liaison meetings and informally during the course of conducting hearings. Finally, an earlier draft of this Chapter was reviewed by a leading psychiatrist in child and adolescent mental health.

¹⁶⁸ For up-to-date information about the demographics of patients in Tribunal hearings see the Tribunal's [quarterly activity reports](#) on our website and our [Annual Reports](#).

¹⁶⁹ Victoria Legal Aid, Response to Mental Health Tribunal's discussion paper, 19 August 2015, p. 4.

¹⁷⁰ Ibid.

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- 171 Participant at CAMHS / CYMHS Clinical Leaders Group 19 August 2015.
- 172 Orygen Youth Health, young person. Email dated 8 July 2015.
- 173 Orygen Youth Health, family peer support worker. Email dated 30 July 2015.
- 174 Orygen Youth Health, young person. Email dated 8 July 2015.
- 175 Tribunal Member, Legal. Submission dated 18 June 2015.
- 176 Ibid.
- 177 Ibid.
- 178 Participant at CAMHS / CYMHS Clinical Leaders Group 19 August 2015.
- 179 Ibid.
- 180 Victoria Legal Aid, above n 169, p. 4.
- 181 Tribunal Member, Medical. Email dated 1 August 2015.
- 182 Ibid.
- 183 Tribunal Member, Psychiatrist. Email dated 16 August 2015.
- 184 Tribunal Member, Legal. Submission dated 18 June 2015.
- 185 Carney et al, above n 4, p 279.
- 186 Participant at CAMHS / CYMHS Clinical Leaders Group 19 August 2015.
- 187 Tribunal Member, Psychiatrist. Email dated 2 June 2015.
- 188 Orygen Youth Health, clinician. Email dated 8 July 2015.
- 189 Orygen Youth Health, young person. Email dated 8 July 2015.
- 190 Victoria Legal Aid, above n 169, p. 4.
- 191 Carney et al, above n 4, p. 178.
- 192 Orygen Youth Health, young person. Email dated 8 July 2015.
- 193 Recovery Oriented Language Guide, above n 5, p. 12.
- 194 Tribunal Member, Medical. Email dated 1 August 2015.
- 195 Ibid.
- 196 Tribunal Member, Psychiatrist. Email dated 16 August 2015.
- 197 Victoria Legal Aid, above n 169, p. 5.
- 198 Orygen Youth Health, young person. Email dated 8 July 2015.
- 199 Tribunal Member, Legal. Submission dated 18 June 2015.
- 200 Tribunal Member, Psychiatrist. Email dated 2 June 2015.
- 201 Tribunal Member, Psychiatrist. Email dated 29 May 2015.
- 202 Orygen Youth Health, young person. Email dated 8 July 2015.
- 203 Participant at CAMHS / CYMHS Clinical Leaders Group 19 August 2015.
- 204 Orygen Youth Health, family support worker. Email dated 30 July 2015.
- 205 Victoria Legal Aid, above n 169, p. 5.
- 206 Tribunal Member, Medical. Email dated 1 August 2015.
- 207 Carney et al, above n 4, p. 294.
- 208 However, the 'views and preferences' principle (section 11(1)(c)) must be balanced against other principles and objectives of the Act, for example, the 'best interests' principle (section 11(1)(i) which states that: children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration.
- 209 *Mental Health Act 2014*, s. 11(1)(k) and (l); s. 55(2).
- 210 Participant at CAMHS / CYMHS Clinical Leaders Group 19 August 2015.
- 211 Victoria Legal Aid, above n 169, p. 6, with minor changes
- 212 Department of Health 2011, *Framework for recovery-oriented practice*, State Government of Victoria, Melbourne.
- 213 See 3.3.3 '*Embedding recovery-oriented practice.*'
- 214 Victoria Legal Aid, above n 169, p. 6.
- 215 Recovery Oriented Language Guide, above n 5, p. 12.
- 216 Ibid.
- 217 Tribunal Member, Psychiatrist. Email dated 16 August 2015.
- 218 Tribunal Member, Medical. Email dated 1 August 2015.
- 219 Ibid.
- 220 Ibid.
- 221 *Mental Health Act 2014*, s. 55(2)(a) for example.

²²² Orygen Youth Health, Family Peer Support Worker. Email dated 30 July 2015.

²²³ Ibid.

²²⁴ Ibid.

²²⁵ Victoria Legal Aid, above n 169, pp. 5-6.

²²⁶ Ibid, p. 6.

²²⁷ Tribunal Member, Psychiatrist. Email dated 2 June 2015.

²²⁸ Victoria Legal Aid, above n 169, pp. 6-7.

²²⁹ Tribunal Member, Legal. Submission dated 18 June 2015.

²³⁰ Carney et al, above n 4, p. 304.

²³¹ Victoria Legal Aid, above n. 169, p. 6.

Chapter 8 Solution-focused hearings for older people

- This Chapter focuses on how to address the complex issues that can hinder or prevent older persons (65+ years) actively participating in Tribunal hearings.
- Medication for mental illness can have an unwanted effect on physical health and treatment for physical illness can sometimes adversely affect a person's mental health.
- Issues that can arise more often for older people include: dementia; social isolation, loss, grief and stigma; and challenges associated with being part of an immigrant community.
- Practices and strategies members can adopt in hearings for older people include:
 - consider and ask if the older person has mobility and sensory needs including hearing and vision impairment
 - take extra time so the older person understands what is happening (without 'talking down' to the person) and promote the use of supported decision-making mechanisms such as advance statements and nominated persons
 - remember the participation of support people should not be at the expense of the voice of the older person
 - demonstrate respect and support the choice and autonomy of the older person through the Tribunal's language (including by reflecting the presumption that the person has capacity)
 - speak with the older person directly whenever possible rather than 'defer' to the older person's carer or family members
 - remember that input from the older person's carer or family members sits alongside rather than replaces the older person's view
 - rely on independent, professional interpreters in hearings rather than family members
 - take the time to explain the decision in easy and understandable language and allow some time for answering questions following the decision.

This Chapter explores the complex issues that can hinder or prevent older persons actively participating in hearings. It also contains practical guidance about how these issues can be addressed and how hearings can be improved for people aged 65+ years. The case studies and consumer vignettes come from consultation during the development of this Chapter.²³² On average, approximately 10 per cent of hearings involve people aged 65+ years.²³³

8.1 Who is an older person with mental illness?

It is acknowledged that people age or experience the effects of aging at different points in their life. SANE Australia (SANE) reports that:

Although older age is usually defined as 65 years and above, the needs of older Australians living with mental illness can be different to the general population. Older people with mental illness are more likely to have multiple physical health conditions, cognitive impairments and few supports, and to experience financial difficulty. These factors contribute to an increased likelihood of needing supported accommodation or experiencing the effects of ageing much sooner. These factors also lead to severely reduced life expectancy; people living with mental illness live on average 25 years less than the general population.²³⁴

Similarly, people living in disadvantaged communities may also require support services typically needed by older people before they are aged 65 years. As the Australian Bureau of Statistics (ABS) reports:

Particular groups (notably Aboriginal and Torres Strait Islander people) can require various services at a younger age. One in four people aged 70 years and over plus Aboriginal and Torres Strait Islander people aged 50-69 makes some use of aged care. While most remain in their own home and use community care, one in ten uses a residential care facility.²³⁵

While this Chapter focuses on people aged 65+ years, it is preferable to avoid a rigid adherence to age-specific classifications and to adopt a flexible approach when responding to the diverse support needs of people with age-related conditions and mental illness.

8.1.1 Particular issues affecting older people

The Tribunal has an important role to play in promoting and protecting the rights of older people subject to compulsory mental health treatment. Older people experiencing mental health issues, mental illness and compulsory treatment are often more vulnerable to social isolation, poverty, emerging cognitive impairments, family violence and physical health issues than other cohorts.²³⁶

While the circumstances affecting particular individuals will vary, certain issues, such as those identified in Victoria Legal Aid's submission in the quotation above, plus ambulation difficulties and sensory deficits, tend to disproportionately affect older people accessing mental health services.

The issues of physical health, dementia, social isolation, loss and grief, stigma and older persons from immigrant communities are explored further below. Issues relating to ambulation and sensory impairment are addressed in [section 8.2.1](#) 'Preparing for a Tribunal hearing' and the issue of family violence / elder abuse is discussed in [section 8.2.2](#) relating to the role of carers and support people.

As explored in Chapter 2, the Tribunal is expected to take a holistic approach in hearings. This means the Tribunal should explore the individual needs and circumstances of the older person, not just their mental illness and the legal criteria set out in the Act. This may include exploring with the older person and support people the issues identified below and how they can be addressed.²³⁷ As a first step it is important the Tribunal is aware of common issues that can affect older people.

It is important to note the issues described below may not necessarily be present in all (or even most) cases and there may be other important issues affecting older people. Submissions to the Tribunal emphasised that older people are not a homogenous group and that the Tribunal must be 'vigilant to ensure that its findings are properly grounded in evidence, rather than age-based assumptions and stereotypes'.²³⁸

As one Tribunal member put it:

Each occasion is different and we should never assume that just because a person is older that they do not have the capacity or intellect of others...

*We should not assume that older people do not have the same needs for love, companionship, sexual closeness as people in their younger years. Equally, we should not assume that older people do not have an interest in other aspects of life such as travel, the arts, work and socialising.*²³⁹

Physical health

A SANE study conducted with the aim of better understanding the lived experience of older people with mental illness reports that physical health was one of the main issues older people and their support people identified as affecting their quality of life.²⁴⁰

Sixty per cent of respondents reported the medication they take for their mental illness had an unwanted effect on their physical health. Similarly, mental health practitioners confirmed that treatment for physical illnesses can adversely affect a person's mental health condition,²⁴¹ such as medication-induced confusion or delirium. Sometimes it is not entirely clear whether symptoms such as confusion or delirium are due to mental illness or a medication for a physical illness.

8.1.2 Exploring physical health issues in Tribunal hearings

Given the importance of physical health to the wellbeing of people with mental illness and the Act's explicit recognition of holistic responses to the needs of people receiving mental health services,²⁴² critical information concerning a person's physical health should form part of the information the treating team gives the Tribunal.

This information is important for the Tribunal to be able to satisfy itself that particular symptoms are the result of mental illness rather than a physical illness. [Section 8.2.1](#) of this Chapter discusses the hearing report in more detail. Accordingly, the Tribunal should explore any physical health issues affecting the older person as part of adopting a holistic approach. In particular, the Tribunal should ask about:

- the interaction of physical health conditions with the older person's mental illness (for example, could some symptoms be the result of the physical health rather than mental health condition?)
- whether side effects of medication for the older person's mental health condition have an unwanted effect on their physical health or whether side effects of their medication for their physical health condition have an adverse effect on their mental health condition.

Dementia

In considering the needs of older people, it is important to keep in mind that in Tribunal hearings for someone with dementia, it can be difficult to distinguish between depression and dementia. As Beyond Blue notes:

Depression is thought to affect 1 in 5 people experiencing dementia.

When dementia and depression occur at the same time it may be difficult to distinguish between them because the signs and symptoms are similar. However, dementia and depression are very different conditions that require different responses and treatment, so a thorough assessment by a health professional is recommended.²⁴³

Another difficulty is that symptoms of dementia can interfere with the ability of older persons to participate in hearings.

8.1.3 Tribunal hearings for older persons with dementia

Due to these complexities, it is preferable to adopt a particularly low key, informal approach when conducting a hearing for a person with dementia. Tribunal members should take special care to use clear and concise language and short sentences.²⁴⁴

Various stakeholders also expressed views about the use of video-hearings for older persons generally but particularly those with dementia. The use of video hearings for older people generally is discussed further in [section 8.2.2](#): Conducting the hearing.

Finally, when an older person has dementia and their symptoms limit their ability to participate in the hearing, the participation of a carer, nominated person, lawyer or advocate is likely to be particularly important. Services can play an important role in encouraging this cohort to obtain legal representation or advice before their Tribunal hearing.

Social isolation, loss and grief and stigma

Recent research by SANE also points to social isolation, loss and grief and stigma around mental illness as issues which disproportionately affect older persons. The Tribunal should be aware of the potential impact of these issues when conducting a hearing. This is consistent with holistic and recovery-oriented approaches which are central features of solution-focused hearings (see [section 2.5](#) and [section 3.3](#) of this Guide).

Thirty-one per cent of respondents to the SANE report saw social isolation as a major concern for their future. As SANE reports:

Researchers increasingly understand isolation as a contributing factor to ill health and early death. It should therefore be a focus of all discussions to improve the care and support provided to older adults living with mental illness.²⁴⁵

Similarly, the experience of loss and grief was a major issue for older people participating in the study, with 72 per cent reporting their symptoms changed as they became older. Forty-eight per cent experienced feeling more depressed and most attributed this to loss and grief:

Older adults living with mental illness experience loss in relation to issues such as independence, status, death of a loved one, and financial stability. The stress associated with many of these losses may contribute to depression in later life.²⁴⁶

However, as SANE observes:

Depression is not a normal part of ageing, and yet this assumption can prevent health professionals and care workers from identifying older people who are not coping.²⁴⁷

The higher incidence of depression is complicated further by stigma. As Beyond Blue reports:

Many people over 65 still seem to feel there is a stigma attached to depression and mental health conditions, viewing them as a weakness of character rather than a health problem.

Older people are also more hesitant to share their experiences of depression with others, often ignoring symptoms over long periods of time and only seeking professional help when things reach crisis point.²⁴⁸

For older people, the dual stigma of age and mental illness is pervasive and can affect all aspects of a person's life. SANE reports it can also limit the services an older person receives:

Stigma is a huge issue for this group, and it prevents people from being given adequate care. This group is most often likely to need help, but less likely to be provided with this help.²⁴⁹

Exploring sensitive issues such as social isolation, loss and grief

The Tribunal should endeavour to understand an older person's life circumstances (which may include social isolation, grief and loss), by discussing strategies for sensitively exploring those issues while considering the persons attending a hearing (for example, relatives) and recognising the older person may be too embarrassed or uncomfortable to discuss these issues. Even if it is not possible or appropriate to discuss certain sensitive issues, the Tribunal may be well placed to explore what community support may be available to support the older person with these issues if they prefer this.

Despite the fears they hold for their future, 67 per cent of the older people with mental illness surveyed by SANE had not spoken with their carer or support person about a plan for their future care.²⁵⁰ For this reason, if the older person is at the hearing, the Tribunal should explore their preferences around their mental health treatment and care (including their living arrangements) with them. Similarly, the Tribunal should request the treating team outline the current wellness and recovery plan, describing how the person's treatment preferences for their current and future care are being addressed.

Immigrant experience

Victoria Legal Aid's submission highlights particular challenges that older persons from immigrant communities may face:

Our aging population includes immigrant communities, many of whom migrated to Australia as adults following World War 2 and who may not be

*fluent in English. Elderly women migrants in particular may have lived within their families and migrant communities for most of their lives in Australia and not had opportunities to participate in the Australian community more broadly. They are profoundly disadvantaged when exposed to the mental health system. There is a myriad of issues around traditional gendered roles of older people and other cultural norms that may not sit well with the prevailing model of disclosure and treatment of mental illness within our health system.*²⁵¹

Similarly, a psychiatrist member of the Tribunal stated that people from immigrant communities may have been subject to:

*...significant stressful background events such as war-time experiences, deprivations, deportations, family losses, racial or religious discrimination, immigration experiences and coping with financial disasters.*²⁵²

8.1.4 Exploring issues relating to migration

Tribunal members need to demonstrate sensitivity and compassion around issues relating to migration in their questioning, being careful to explore only what is relevant for the person and for the decision the Tribunal is required to make. The Tribunal should be mindful of the older person's distress, and monitor how well they are tolerating and / or understanding the questioning.²⁵³

The importance of professional interpreters for this cohort of older people cannot be overstated and is discussed more in section 8.2.1 below: Preparing for a hearing.

8.2 Practices and strategies in hearings for older people

This section outlines practices and strategies that can be adopted in hearings for older people in the three main phases of the hearing process:

- preparing for a hearing
- conducting the hearing
- concluding the hearing and delivering the decision.

The practices discussed below relate to the Tribunal and to the treating team, who have a vital role in assisting older people to prepare for their hearing and in preparing the report before the hearing.

8.2.1 Preparing for a hearing

Carney et al identified that patients, families and carers have limited understanding of the role of mental health tribunals and are often unprepared for hearings:

*For the client to have a greater role in participating in the hearing, and for this to be a useful experience, it appears that informing the person in clear terms about what to expect at a hearing is essential. This involves not only outlining the criteria but also being clear as to how these may be discussed, what type of experiences are important to highlight, along with what questions and concerns are appropriate to raise. Having assistance to reflect on these issues and what might be helpful for the client in terms of their future treatment and/or access to resources, as well as how they can be aided in telling their story before or on the day of the hearing would benefit from attention.*²⁵⁴

This section explores ways of improving preparation for Tribunal hearings, focusing on the hearing report, the treating team's role in explaining the hearing report and hearing processes, and addressing specific needs relating to mobility and sensory difficulties.

The importance of including the right information in the hearing report

The hearing report is the key document the treating team must prepare before a Tribunal hearing. The Act requires the service to give patients access to this report and other documents related to a hearing at least 48 hours before the hearing.

Submissions focused on the content of this report, the timeliness of giving it to the older person and how it is explained to them and / or their carers / nominated person as appropriate.

Submissions to the Tribunal indicated that it would be beneficial for services to include more information in reports for older people about the medical issues they are experiencing, all current medications, and any relevant social circumstances. It was also emphasised that a good history is important. As a practitioner at the meeting of the aged persons mental health leaders' network put it, 'we can't treat people in the future if we don't know about the past'.

Victoria Legal Aid submitted that:

It would be beneficial for the report to include commentary on any relevant history of physical illness, effects of antipsychotic medication on physical health, social isolation, grief or loss or other issues being experienced by the older person. It would also be useful for the report to include a more detailed breakdown of medications taken for both physical and mental illness.²⁵⁵

Treating team's role in explaining the hearing report and the hearing process

The Tribunal's Practice Note on Access to Documents in Tribunal hearings makes it clear the Tribunal considers there is:

a positive obligation on the service to facilitate patient access to information in the clinical report which can include the provision of an interpreter or other assistance the patient requires in order to understand the contents of the clinical report.²⁵⁶

This is also required under section 8 of the Act, which requires the contents of any advice, notice or information given to the person to be explained:

to the maximum extent possible to the patient in the language, mode of communication and terms which the patient is most likely to understand.²⁵⁷

In the case of older people, assisting them to read and understand the report could include providing the report in large print.²⁵⁸ To properly explain the report to an older person, the treating team may need to have several sessions with them, meaning the process should start well before the 48-hour minimum timeframe.²⁵⁹

This means the practice adopted in some services, where the interpreter is engaged for the hearing and translates the report for a person just before the hearing is not desirable. It should be avoided in all but the most urgent cases. A fundamental rule of procedural fairness is that a person has opportunity to prepare for their hearing. The

Tribunal can adjourn a hearing if there are concerns the person has not had adequate opportunity to read the hearing report (and / or have it explained to them).

More generally, while Tribunal guidelines and other resources are available to explain Tribunal processes, service staff are usually best placed to explain the process to the older person and their support people before the hearing. Participants in the meeting of the aged persons mental health leaders' network commented on the importance of the treating team explaining the purpose of the hearing and that the person is 'not going before a judge to be convicted'. This explanation is particularly important when it is an older person's first hearing, when the process is unfamiliar and when they may be very unwell. As one participant in the meeting of the aged persons mental health leaders' network put it, some older persons are petrified: 'they think they'll be shot'.²⁶⁰ Other participants at the same meeting commented that if the hearing goes badly because the patient has not been properly prepared for it (for example, if they do not understand what the Tribunal is there to decide), the hearing can be an upsetting experience for the treating team, family members and support people but most of all for the older person.²⁶¹

Specific ambulatory and sensory needs²⁶²

Older people are generally more likely than younger people to have support needs relating to mobility or hearing and sight impairments. The Tribunal should be made aware of and prepare for these needs before a hearing to avoid any delay in its start or any embarrassment or stress for the older person.

Mobility

For mobility issues, it is important the treating team enable the person to attend the hearing. For community patients, this might mean organising transport to and from the hearing. Wheelchair and mobility aid access should be facilitated. The Tribunal should be informed if a person will be attending in a wheelchair or other mobility device so adequate space is provided before the person enters the room.

Preparation for sensory impairment

For people with hearing loss, low or no vision, it is essential to recognise that each person's needs will be individual to their specific abilities and preferences. These abilities and preferences should be communicated to the Tribunal in advance and verified with the person at the start of the hearing.

Hearing impairment

The Tribunal understands that all aged mental health services should have access to headphone and microphone sets for hearing impaired people. In addition, people with low hearing will generally need clear vision of the speaker and be able to see their lips moving. Position may be important as the older person may favour one ear over the other and so the Tribunal should be flexible about seating arrangements (see case study on 'Jimmy' below). Care should be taken so the full conversation is heard, not just the questions directed to the person. It may be appropriate to have someone seated next to the person such as a clinician, family member or support person (someone with a familiar voice) to repeat what is being said and / or for the Tribunal to adjust its seating to be closer to the person.

If an Auslan (sign language) interpreter is required, it is important to remember that two interpreters will often need to be booked as Auslan interpreters can only interpret

for limited periods of time before a break is required or before needing to swap with another interpreter. Using Auslan interpreters requires the same oversight as mentioned in the section 8.2.2: Importance of professional interpreters.

Vision impairment

As previously stated, it is important that a person with vision impairment has access to written material in large print and / or has the relevant material read to them. The Tribunal should check this has occurred at the start of the hearing and if not, deal with this issue accordingly.

Notwithstanding the fact that all parties will have introduced themselves, depending on a person's ability to see, it might be necessary for the Tribunal to state their name on each occasion before they speak and when speakers change. For example, 'this is Helen, the community member...' All participants should be prompted to do this.

Some people with age-related vision impairment such as macular degeneration might look like they can see you, as they will automatically 'look' at you when you're speaking. It can be easy to forget or minimise the sight impairment. Additionally, without sight a person does not have the visual clues to aid communication such as seeing facial expressions, gestures and hand movements so it is vital the Tribunal monitors proceedings with this in mind.

People with vision impairment are easily startled by sudden movement or loud noise so this should be avoided and explanation given before any movement. For example, 'This is Mary, the legal member, I am handing over the document explaining our decision today...' or 'We're about to break to discuss our decision. Everyone here other than the Tribunal is going to leave the room...'

During hearings for people with hearing or vision impairment, the Tribunal should regularly check to ensure the person is following and understanding proceedings and, of course, the decision of the Tribunal.

8.2.2 Conducting the hearing

Engaging older persons in hearings

Carney et al reported that:

*The hearing is very stressful for consumers, exacerbated by their mental illness. Many used terms such as trial, punishment, powerlessness and intimidation...*²⁶³

To demonstrate the Tribunal is responsive to the views and preferences of the older person, an increasingly common practice in hearings is to initially focus on these topics as well as their social and community support, before shifting to the person's mental health and wider discussion with the treating team. If an individual seems to find this approach confronting, the discussion might start with the treating team or with a carer / family member. As one Tribunal member commented, asking the person about their circumstances can be embarrassing for some people and can raise privacy issues.²⁶⁴ Also see the discussion in [section 8.2.1](#) about exploring sensitive issues.

Submissions emphasised the need to take extra time in hearings involving older people so they understand what is happening. However, it is equally important not to ‘talk down’ to the person. As members observed:

We should be kind, gentle and slow things down. Older people should not be rushed but also we should not be condescending in our manner. Respect for the person should be demonstrated at all times ... [e.g.], addressing them with their full title: Mr, Mrs, Ms, Dr etc., if this is their preference.²⁶⁵ (Tribunal member, community)

Hearings may be more time-consuming because of the need for extra attendees, interpreters (elderly [people] from non-English speaking background[s] can be less proficient regarding technical terms even if they can speak English), handicaps due to attentional [sic] difficulties and sensory deficits. Time should be allowed for repetition of information and questioning and confirmation that material has been understood.²⁶⁶ (Tribunal member, psychiatrist)

Tribunal members should always introduce themselves at the start of the hearing but simplifying introductions and the explanation about the hearing process may be desirable in hearings involving older people.²⁶⁷ As Victoria Legal Aid submitted:

... [I]t can be helpful for the Tribunal to dispense with formalities when dealing with older people. In our experience, consumers are often stressed by the hearing process and consequently unable to quickly and easily process information. In these situations, it is important that the Tribunal explains the hearing process simply and makes the forum appropriately informal in order to reduce stress.²⁶⁸

‘Jimmy’

Jimmy was an elderly man experiencing his first admission to an inpatient facility. English was not his first language and he was partially deaf and very anxious about his hearing. He did not believe he had a mental illness nor that he required ongoing treatment.

The Tribunal put him at ease by acknowledging his age and great life experience and by explaining things simply and easily and answering questions as they arose. The Tribunal also rearranged the configuration of the hearing room so the atmosphere was more conversational. This included seating Tribunal members next to Jimmy to maximise his ability to hear and participate in the hearing. It led to a stronger more robust discussion of the issues during the hearing. Jimmy indicated he was very appreciative of the way the hearing was conducted. He felt listened to, involved and respected.²⁶⁹

A number of submissions emphasised the importance of advance statements and other tools that can support older people to prepare for discussions and make or participate in decisions about their treatment for mental illness.²⁷⁰ The treating team has a role in telling the person about these supported decision-making mechanisms well before the Tribunal is involved. However, the Tribunal can also promote their use during the hearing.

By according significant weight to the input of a nominated person and the content of an advance statement, the Tribunal can promote supported decision making. Alternatively, if a person does not have a nominated person or advance statement, the Tribunal may suggest ‘flagging these as something they may want to consider and discuss with their treating team in the future’.²⁷¹ As Victoria Legal Aid stated:

*While it is not the role of the Tribunal to direct the use of tools such as advance statements, there is scope for decision-makers to discuss and promote the use of these tools in the context of Tribunal hearings.*²⁷²

Role of carers, support people

As noted elsewhere in this Guide, particularly in Chapter 9, the Act promotes the recognition of and respect for the central role of carers and support people.²⁷³ The Tribunal encourages the participation of family and other support people in Tribunal hearings involving older persons (as it does in hearings of people of any age).

However, the participation of support people should not be at the expense of the voice of the older person. As people age, there is ‘increased potential for older people to become marginalised in ... hearings as their carers take up a more active role’:²⁷⁴

*Many age-based assumptions made about older people are grounded in a “best interests” model that may conflict with the wishes and preferences of the older person themselves. In the context of the provision of mental health treatment and Tribunal hearings, there is a very real risk of deferring to the opinions of family and carers where the older person receiving treatment may already be experiencing a profound loss of control over their life.*²⁷⁵

The *Recovery Oriented Language Guide* emphasises it is vital that older people are supported to have their voice heard and their choices understood and advises:

Older people should be reassured that their autonomy and ability to self-determine life choices will not be undermined unnecessarily, especially when other disabilities may be involved.

*Avoid asking others, even those close to them about what they want, unless a person clearly wants someone else to speak on their behalf, or are unable to communicate their preferences.*²⁷⁶

This means it is important the language the Tribunal uses demonstrates respect and supports the choice and autonomy of an older person. It should reflect the presumption that the person has capacity²⁷⁷ and is able to express their own preferences or be assisted to do so.

The Tribunal should also be aware of the stress that carers are often under and the potential for elder abuse (a form of family or domestic violence or exploitation experienced by older people).²⁷⁸ This phenomenon is increasingly common and has multiple forms that go beyond physical and financial issues and extend to emotional and psychological abuse and neglect.²⁷⁹ As one recent study states:

*...the extent of elder abuse is sufficiently large that social service and health professionals who serve older adults are likely to encounter it on a routine basis.*²⁸⁰

Victoria Legal Aid reports that elder abuse is a particular issue for elderly women and notes that:

It is highly problematic when the partner in the relationship is used as the primary source of information or is treated as the person's carer by the treating team, with no acknowledgement of the dynamic of gender-based violence and control occurring in the relationship.²⁸¹

In light of these issues, it is preferable the Tribunal speak with the older person directly whenever possible rather than defer to the older person's support people. As a corollary, it is important to remember that input from the older person's carer or family members sits alongside rather than replaces the older person's view. When raised by the treating team or advocates or identified by the Tribunal, any concerns about abuse or power imbalances need to be handled sensitively on a case-by-case basis.

'Maria'

Maria is 68 years old and has been involved with the mental health system for many years. Recently she has been in and out of hospital and subject to compulsory treatment. Maria's husband attends all appointments and treatment meetings with her. Maria is not confident speaking in English but her husband is confident and speaks English well. Maria's husband also contacts the Crisis Assessment and Treatment Team, leading to Maria's admissions into hospital.

Maria is rarely provided with an interpreter as staff communicate with her in English. Maria's husband often speaks with the treating team about his preferences for her mental health treatment and this appears to inform their decisions about her medication and discharge planning.

Maria has told her lawyer that she sometimes doesn't understand what the treating team is saying. It is clear that she relies on her husband to explain what the treating team is saying. However, he often doesn't tell her or simply tells her she is sick and needs to take medication she is given.

Maria has stated her husband gives her the medication and that the psychiatrist asked him to do this so that she takes it; she states that her husband sometimes does not give it to her. Maria does not know what the medication is and she often feels physically sick from it.

Maria has spoken to her lawyer about the family violence that began in the relationship over 40 years ago. Maria has said she is scared to ask that her husband not attend meetings with her and also feels she has not had a chance to tell the treating team what she wants.

Maria also told her lawyer that during Tribunal hearings her husband often answers for her and stated that he was her carer despite the fact that she does all the housework and caring at home, even when she feels unwell. No interpreter was used as Maria's husband insisted he could assist her and Maria was afraid to say that she needs an interpreter.

Maria stated she feels her views are dismissed as she has bipolar and is perceived to not know what it is she needs. Instead her husband is referred to as the expert in her treatment.²⁸²

Importance of professional interpreters

The case study of Maria highlights the need for independent, professional interpreters. When notified of the need for an interpreter, the Tribunal's policy is to engage independent, qualified interpreters for hearings (including for the interpreter to be available for 15 minutes before and after the hearing). Where a service has not identified the need for an interpreter but it becomes clear that one is required, the Tribunal may be able to arrange a telephone interpreter at short notice or exercise its discretion to adjourn the hearing so an interpreter can be arranged.

When using an interpreter, Tribunal members must be mindful they are speaking with the older person who is the subject of the hearing. Questions and conversation should be addressed directly to the older person and not to the interpreter in the third person. Tribunal members must also ensure that everything; that is all conversation regardless of who it is directed to, is interpreted, leaving time for the interpreter to both understand the content of the conversation and relay it in the required language.²⁸³

Ultimately, professional, independent interpreters should be used wherever possible in discussions with the treating team about the report and the hearing so the person can fully participate.

Video-conference hearings

Views about video hearings for older people were somewhat mixed but a common view expressed was that video hearings should be avoided if possible for persons with dementia. One Tribunal member commented that:

*[Video hearings] can be very confusing; talking to the TV is not normal and might cause unnecessary distress. One elderly person at a video hearing was convinced that he was being filmed because he saw his image in the corner of the screen at his end.*²⁸⁴

Another member mentioned the difficulty of video hearings for older persons with age-related hearing and visual impairments as well as their lack of familiarity with technology.²⁸⁵

In contrast, a participant at the meeting of the aged persons mental health leaders' network with whom others agreed commented that the quality of the video conference connection with the Tribunal is very good and that older people do not have as many difficulties with video conference hearings as anticipated. A video conference hearing with the key people present is preferable to an in-person hearing that is missing key people.²⁸⁶

Victoria Legal Aid took the view that hearings for older people should always be conducted in-person, stating that:

*Video hearings can prevent older people from engaging fully with Tribunal members, leading to misunderstandings about a person's personal circumstances, life history and treatment preferences. In addition to mental illness, older people may also be experiencing difficulties with hearing and visual impairments, making communication via video conferencing challenging.*²⁸⁷

The Tribunal's approach to video hearings for older people

The Tribunal acknowledges concerns about video-conference hearings for older people and has recently altered its hearing schedule so that most hearings at aged mental health services are held in-person rather than by video conference. However, not all hearings involving older persons are held at these services and it is not possible to conduct in-person hearings in all cases involving older persons at aged services or other locations. In these cases, hearings are held by video-conference.

Nevertheless, if particular concerns about a hearing via video-conference are identified before a hearing is listed, the Tribunal's registry may be able to convene an in-person hearing.

Alternatively, if there are issues with an already listed video-conference hearing that make it difficult for an older (or any) person to participate in their hearing, a Tribunal division may exercise its discretion to adjourn the hearing to an in-person division. However, due to the restrictions on the Tribunal's power to adjourn hearings, this will not always be possible.

8.2.3 Concluding the hearing

Consumers were often confused about what the tribunal had decided... Some consumers wanted to be able to discuss or clarify the decision but did not feel they had an opportunity to do so. (Carney et al)²⁸⁸

While the above quotation refers to consumers in general, it is especially true of particularly vulnerable groups of people such as younger and older persons. Participants at the meeting of the aged persons mental health leaders' network felt the level of explanation following hearings (and by whom) needed to be decided on a case-by-case basis.

In Victoria Legal Aid's view, as in all hearings, the Tribunal should take the time to explain the decision to older persons in easy and understandable language, noting this may include 'answering questions that may seem irrelevant to the Tribunal process but are important for the older patient'.²⁸⁹

Tribunal members are provided with guidance about how to deliver their decisions using plain language that is clear, articulate and appropriately concise so that participants understand the decision and the reasons for it. Having regard to all the circumstances of the case, particularly the older person's cognitive level and general level of understanding, members should take particular care so they clearly explain the decision to the older person and allow time for answering questions following the decision.

²³²The Chapter incorporates input from the Office of the Chief Psychiatrist and attendees at a state-wide meeting of the aged persons mental health leaders' network. Professor Daniel O'Connor, Deputy Chief Psychiatrist Aged Persons Mental Health reviewed an earlier draft of this Chapter. Input was also provided by Victoria Legal Aid.

²³³ For up-to-date information about the demographics of patients in Tribunal hearings see the Tribunal's [quarterly activity reports](#) on our website and our [Annual Reports](#).

²³⁴ SANE, 2013, *Growing older, staying well mental health care for older Australians*, p. 1.

²³⁵ Australian Bureau of Statistics (ABS), *Year Book Australia*, 2012.

²³⁶ Victoria Legal Aid, *Solution-Focused Hearings with Older People*, Submission to the Mental Health Tribunal, 27 June 2016, p. 2.

²³⁷ See section 2.5: [Holistic approaches](#).

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- ²³⁸ Victoria Legal Aid, above n 236, p. 4.
- ²³⁹ Tribunal member, Community, submission dated 20 May 2016.
- ²⁴⁰ SANE, above n 234, p.3.
- ²⁴¹ Participants at the meeting of the aged persons mental health leaders' network on 28 June 2016.
- ²⁴² Section 11(1)(f) *Mental Health Act 2014*.
- ²⁴³ Beyond Blue, <https://beyondblue.org/resources/for-me/older-people/signs-and-symptoms-of-depression-in-older-people>. (As at September 2015).
- ²⁴⁴ Tribunal member, Community, submission dated 20 May 2016. A carer on the Tribunal Advisory Group (TAG) similarly stated that when an older person has dementia the Tribunal should 'disregard formal introductions and explain gently and simply what the process is about'.
- ²⁴⁵ SANE, above n 234, p. 8.
- ²⁴⁶ Ibid.
- ²⁴⁷ Ibid.
- ²⁴⁸ Beyond Blue, <https://www.beyondblue.org.au/resources/for-me/older-people>. (As at September 2015).
- ²⁴⁹ SANE, above n 234, p. 9.
- ²⁵⁰ Ibid.
- ²⁵¹ Victoria Legal Aid, above n 236, p. 4.
- ²⁵² Tribunal member, Psychiatrist, email dated 21 May 2016.
- ²⁵³ Tribunal member, Community, submission dated May 2017.
- ²⁵⁴ Carney et al, above n 4, p. 295.
- ²⁵⁵ Victoria Legal Aid, above n 236, p. 7.
- ²⁵⁶ Practice Note 8 – Access to Documents in Mental Health Tribunal Hearings, paragraph 40.
- ²⁵⁷ Section 8(2) provides that such an explanation 'must, whenever reasonable, be given both orally and in writing.' It is worth noting that Division 1 of Part 3 of the Act requires the service to give and explain a statement of rights to persons that sets out their rights under the Act while being assessed or receiving treatment in relation to their mental illness and which contains information as to the process by which a person will be assessed or receive treatment. Statement of rights documents are available in a range of community languages and contain information about Tribunal hearings.
- ²⁵⁸ Victoria Legal Aid, above n 236, p. 7.
- ²⁵⁹ Ibid.
- ²⁶⁰ Participants at the meeting of the aged persons mental health leaders' network on 28 June 2016.
- ²⁶¹ Ibid.
- ²⁶² This section draws from the submission of a Tribunal member, Community, submission dated April 2017.
- ²⁶³ Australian Mental Health Tribunals: '*Space for fairness, freedom, protection and treatment?*' Unpublished paper presented to the members of the former Mental Health Review Board in December 2009, p. 7.
- ²⁶⁴ Tribunal member, Legal, email dated 18 May 2016.
- ²⁶⁵ Tribunal member, Community, submission dated 20 May 2017.
- ²⁶⁶ Tribunal member, Psychiatrist, email dated 21 May 2016.
- ²⁶⁷ Tribunal Advisory Group (TAG) and Tribunal member (psychiatrist), email dated 21 May 2016.
- ²⁶⁸ Victoria Legal Aid, above n 236, pp. 7-8.
- ²⁶⁹ Ibid, p. 8, with minor changes.
- ²⁷⁰ Victoria Legal Aid, above n 236, 6, TAG and participants at the meeting of the aged persons mental health leaders' network on 28 June 2016.
- ²⁷¹ See section 3.2: [Self-determination and supported decision making](#).
- ²⁷² Victoria Legal Aid, above n 236, p. 6.
- ²⁷³ See also, section 3.4: [Inquisitorial and informal nature of Tribunal hearings](#). Section 10(h) of the Act provides that an objective of the Act is 'to recognise the role of carers in the assessment, treatment and recovery of persons who have mental illness.' Similarly, there are two mental health principles in section 11 that specifically recognise the important role of carers, namely: (k) carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible; and (l) carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.'
- ²⁷⁴ Tribunal member, Community, email dated 30 May 2016.
- ²⁷⁵ Victoria Legal Aid, above n 236, p. 4.
- ²⁷⁶ Recovery Oriented Language Guide, above n 5, p.13.
- ²⁷⁷ Ibid.
- ²⁷⁸ Domestic Violence Resource Centre Victoria (DVRCV), <http://www.dvrcv.org.au/help-advice/elder-abuse-and-family-violence> (as at 2 February 2017).

²⁷⁹ Tribunal member, Community, email dated 30 May 2016.

²⁸⁰ Pillemer, K., Burnes, D., Riffin, C., & Lachs, M. S. (2016). Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. *The Gerontologist*, 56 (Suppl 2), pp. 194-205, 197.

²⁸¹ Victoria Legal Aid, above n 236, p. 4.

²⁸² Adapted from case study in submission of Victoria Legal Aid, above n 237, p. 5.

²⁸³ Tribunal member, Community, submission dated April 2017.

²⁸⁴ Tribunal member, Community, submission dated 20 May 2016.

²⁸⁵ Tribunal member, Legal, email dated 18 May 2016.

²⁸⁶ Participant, meeting of the aged persons mental health leaders' network on 28 June 2016.

²⁸⁷ Victoria Legal Aid, above n 236, p. 8.

²⁸⁸ Carney et al, above n 4, p. 5.

²⁸⁹ Victoria Legal Aid, above n 236, p. 9.

Chapter 9 Involving family, friends, carers and other support people in hearings

- The Chapter provides practical guidance on how mental health services and the Tribunal can work with consumers and their support people to address obstacles to enable them to participate effectively and constructively in hearings.
- The perspective of family, friends, carers and the support they give consumers are important factors in the Tribunal's decision making. This is highlighted in the Act, which states that carers should be involved in treatment and recovery whenever possible and be recognised, respected and supported in their role.
- Strategies from solution-focused hearings and Single Session Family Consultations can help mental health services prepare consumers and their support people for hearings.
- As a first step well ahead of the hearing, it is important that treating teams talk to consumers about who the important people in their life are and whether they might participate in a future hearing. This involves discussing the pros and cons of support people participating in the hearing and clarifying what the consumer considers can be shared or discussed.
- Explaining hearing processes to consumers and their support people and managing their expectations is an important part of preparing them for hearings.
- The decision about who participates in the hearing (or part of a hearing) is made by the Tribunal on a case-by-case basis, taking into account all the circumstances and the views of carers and consumers.
- Tribunal members can negotiate and moderate the participation of support people in hearings by:
 - reassuring the consumer their support person's views provide another perspective for the Tribunal but do not carry more weight than their own
 - restricting the support person's participation to part of the hearing only
 - agreeing on particular parameters for the support person's participation.
- Tribunal members must be aware of inviting support person participation without putting them 'on the spot' and potentially jeopardising their relationship with the consumer.

- It can be helpful to use techniques such as:
 - asking about the consumer's strengths
 - acknowledging, normalising and validating the feelings being expressed
 - reframing the issues and highlight what participants have in common
 - commenting on strengths or positive behaviours
 - checking in with the consumer to see how they are reacting to what is being said
 - inviting participants to respond directly to what others have said
 - summarising any actions participants have agreed to take and give a sense of 'where to from here' (at the end of the hearing).

‘Tony’

‘Tony’ was admitted to hospital as a patient under the Act 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 latest 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 ceremonies and practices. The treating team believed these were grandiose beliefs and symptoms of Tony’s mental illness.

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 lived 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 it was true he was encouraging Tony to visit to complete the initiation ceremonies and other cultural practices.

The Tribunal facilitated a discussion between Tony, his 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. 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 they would work closely with the treating team and seek the treating team’s advice about Tony’s treatment and recovery and when he may be able to travel safely.

Taking into account a range of factors, including his mother’s support, Tony’s willingness to have treatment and his views and preferences, the Tribunal was satisfied 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.

Tony’s hearing highlights the important contribution that family, friends, carers and other support people can make in Tribunal hearings. Tony’s mother’s evidence was an important factor in deciding that Tony could receive treatment in the community instead of in hospital. Tony’s mother also provided an important counterbalance to the assumption that Tony’s beliefs about cultural ceremonies were not based in reality. Without Tony’s mother’s practical support and evidence, it is possible the Tribunal would have reached a different conclusion.²⁹⁰

This case, and others like it, show how a solution-focused approach to hearings involving carers and other support people recognises, respects and supports their important role in the lives of consumers and ongoing treatment and recovery while also safeguarding their rights, dignity and autonomy.

Unfortunately, for a range of reasons explored in this Chapter, some support people do not attend hearings or, if they do, may not feel able to participate constructively. This Chapter provides practical guidance on how the Tribunal and mental health services can address these obstacles and work with consumers and their support people to improve the participation of support people in hearings.

9.1 Terminology

There are divergent views about what to call the people who support consumers in their care and recovery. The 'Note about language' at the start of this Guide states the former Department of Health's *Framework for Recovery-Oriented Practice* (2011) notes that many people do not identify with the term 'carer' and the kind of relationship this term implies. As the Royal Commission into Victoria's Mental Health System interim report put it:

[T]he word 'carer' does not capture the diversity of the relationships involved: carers are parents, grandparents, siblings, partners, friends, neighbours, teachers and others from extended networks. For some individuals who provide care and support, being perceived or described only as a carer is a limiting identity.²⁹¹

For some family and friends, the 'carer' label is tinged with loss and grief. For example, the partner of a person with a mental illness may feel if they identify as a 'carer' then they lose the identify of being (and having) a partner.

Conversely, a consumer may not acknowledge the care they are receiving. This could be to protect their own dignity, because of the stigma of requiring care, or because they do not believe they have a mental illness or need care.

For these reasons, this Chapter also employs the broad terms 'support people' or 'support networks.' These could include peer support workers, friends and housemates as well as family members.

Finally, this Chapter also uses terms and phrases such as 'families' and 'family members' or 'family, friends, carers and other support people' to highlight the synergies with Single Session Family Consultations (explored further below). It is important to emphasise that family is not limited to (and may not even include) biological family members but rather includes a consumer's family of choice.

Nominated persons

Some carers may have been appointed as nominated persons under the Act. Nominated persons support and represent the interests of people being treated under the Act. They help patients exercise their rights and must receive information and be consulted at various points.²⁹² Nominated persons are a mechanism to enable supported decision making, a concept which is central to the Act and is described in [section 3.1](#) of this Guide.

This means support people who are also nominated persons must effectively wear two 'hats' in Tribunal hearings. As the nominated person they are there to support the consumer and represent the consumer's will and preferences. However, as a family member, friend or carer, they may hold and express views that are different from, and perhaps even conflict with, those of the consumer.

9.2 Purpose, framework and structure of this Chapter

The purpose of this Chapter is to provide a coherent framework and practical strategies for encouraging and facilitating the participation of support people in hearings. It is primarily intended to guide Tribunal members and mental health services. It addresses techniques to overcome common obstacles to participation at all stages of the hearing process, including:

- preparing for a hearing
- deciding who attends the hearing on the day
- encouraging participation during the hearing
- concluding the hearing and delivering the decision.

The structure of the Chapter is based on these hearing phases and is also divided into two main parts, namely guidance directed mainly at mental health services and guidance directed mainly at Tribunal members.

As well as drawing on solution-focused hearings principles and the experience of Tribunal members, this Chapter employs principles from the 'Client-centred Framework for Involving Families',²⁹³ particularly Single Session Family Consultations (SSFCs) developed by the Bouverie Centre, Victoria's Family Institute. The Tribunal acknowledges the contribution of Dr Peter McKenzie, Carer Academic, Family Practice Consultant and Clinical Family Therapist at the Bouverie Centre, to this Chapter, particularly in relation to how mental health services can prepare consumers and their families for Tribunal hearings and the strategies based on SSFC techniques more generally.

Another key resource referred to in this Chapter is the Chief Psychiatrist's Guideline on Working Together with Families and Carers.²⁹⁴ Mental health services are encouraged to consult that guideline when preparing consumers and their carers for Tribunal hearings.

Finally, we gratefully acknowledge the input and feedback on this Chapter from a range of organisations and individuals, including the Tribunal's Advisory Group (comprising consumers, carers and members of the lived-experience workforce), Tribunal members, the Office of the Chief Psychiatrist, VMIAC, Tandem, Victoria Legal Aid, and carer consultants or advisors from mental health services.

9.3 Orientation to working with carers and family members and why the participation of support people in hearings is important

Summary

- Evidence shows family and social relationships help the recovery of consumers.
- The perspective of family, friends and carers and the support they provide are important considerations in the Tribunal's decision making.
- The Act emphasises the important role of carers, including in the mental health principles, that carers (including children) should be involved in treatment and recovery whenever possible and have their role recognised, respected and supported.
- The Single Session Family Consultations model is a brief process for engaging and meeting with consumers and their support networks. Many principles and techniques from Single Session Family Consultations can be used to encourage and facilitate carers participating in hearings.

Importance of family and social relationships to recovery from mental illness

While respecting that individual autonomy and self-determination are important features of the solution-focused approach, it is also important to recognise that we are all relational beings. The concept of relational recovery has been described as:

*a way of conceiving recovery based on the idea that human beings are interdependent creatures; that people's lives and experiences cannot be separated from the social contexts in which they are embedded.*²⁹⁵

This means a consumer's family, carers, friends and other support people can support their recovery. As the 'Practical Guide for Working with Carers of People with a Mental Illness' states:

*Family members and carers have a unique role to play in [the journey towards recovery] because they know the person, and probably knew them before they became unwell. They are a source of information about a consumer's life beyond their diagnosis of mental illness, including information about their interests, skills, beliefs and ambitions.*²⁹⁶

While some consumers may be able to recover without the support of their family or other support people, according to the Chief Psychiatrist's guideline there is an established evidence base indicating how the involvement of family benefits the consumer in moving beyond mental illness²⁹⁷.

There is also compelling research that indicates supported family involvement decreases stress for consumers and family members.²⁹⁸ This has a positive effect on

the family's needs as well as on how effectively they support the consumer in their caring role.²⁹⁹

Finally, carers, family and other support people can play a valuable role in supporting the consumer to articulate their views and preferences and to be involved in or make their own decisions. In this way, their involvement can complement the key principles of self-determination and supported decision making.

The unique perspective of support persons can be important to the Tribunal's decision

The perspectives of support people are unique because they are personally invested in the wellbeing of the consumer and are often directly affected themselves by the mental illness of their family member or person they are supporting.

As the Interim Report of the Royal Commission into Victoria's Mental Health System states:

Families and carers often know important things that could help clinicians and care teams in their treatment and care of people living with mental illness. They might be able to relate a person's medical history, past diagnoses or current situation. [...]

The Commission was told that, in some cases, if people working in mental health services have access to this information from families and carers, better outcomes might be more easily achieved. One mother lamented, 'If only there had been some sort of database, to show [her daughter's] escalating pattern of violence. If only someone in authority had noticed this and then consulted her family.'

The Commission has been told of instances where loved ones who live with mental illness become less able to seek help and more fearful about doing so in crisis situations. Families and carers have described their unsuccessful attempts to provide information about the seriousness of their concerns to health services when trying to seek help for a loved one.³⁰⁰

Carers often provide considerably more time and support to consumers than treating teams or other formal supports. According to the Interim Report:

In the context of increasing system constraints, families and carers are important supports for their loved ones in continuing the care provided by mental health services.³⁰¹

These considerations are important to the Tribunal's determination of whether there is a less restrictive means reasonably available to enable the person to receive immediate treatment.³⁰² In hearings this can include exploring a consumer's attitude to receiving care and support from family but should also include exploring support people's capacity and willingness to provide care and what the limits of this might be (such as the carer's own health and wellbeing, age, resources, informal supports, and availability).

Important role of carers is enshrined in the Act

The Act emphasises the important role of families and carers in the recovery of consumers from mental illness. In the Second Reading Speech accompanying the introduction of the *Mental Health Bill 2014*, the then Minister for Mental Health stated:

*Preventing mental illness where possible, providing help early and working with individuals and their families to meet their own recovery goals is central to the government's approach. Together with people with a mental illness, carers, families and services, the Victorian government is building a stronger system in which long-term recovery and support for overall health and wellbeing, social connectedness and economic participation are paramount.*³⁰³

The Act sets down 12 mental health principles to guide the provision of mental health services and to which persons performing duties or functions or exercising powers under the Act, including the Tribunal, must have regard. Two of these principles relate to carers and state:

Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;

*Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.*³⁰⁴

These principles reflect the purposes and principles of the *Carer Recognition Act 2012* which include recognising, promoting and valuing the role of people in care relationships, and supporting and recognising that care relationships bring benefits to the person in the care relationship and to the community.³⁰⁵

9.4 Single Session Family Consultation Model

Emerging evidence suggests the SSFC model is ideally tailored to support a consumer-centred family-inclusive practice. The SSFC model is a time-limited process for engaging and meeting with consumers and their family and support networks to clarify how the family will be involved in the consumer's care and to support family members to identify and address their role as carers as well as their own needs.³⁰⁶ According to the Bouverie Centre:

*The SSFC is a time limited and structured process for meeting with a client and the family and is focused on achieving realistic and negotiated goals [...] this approach has a strong emphasis on the process being consultative, needs driven and strengths oriented. This approach creates a framework that aims to routinely include families in treatment and care and respond to their needs.*³⁰⁷

The SSFC approach advocates directly engaging and supporting the consumer to actively consider and be the central participant throughout the process of planning for family involvement in a session.³⁰⁸ The SSFC model can form part of a comprehensive service response to families and is part of a family-sensitive practice approach.³⁰⁹

While there are clear differences between an SSFC and a Tribunal hearing, many of the principles and techniques of the SSFC approach can be used to encourage and facilitate family members participating in Tribunal hearings. Practical tips and strategies based on SSFCs are covered in the relevant parts of this Chapter.

9.5 Preparing for and conducting hearings with young carers

The Act specifically recognises that young people can be carers³¹⁰ and, in the absence or inconsistency of other forms of support, children and young people do assume a caring role. Young carers often express they are excluded from conversations even though they are directly involved in providing care and decisions can have a significant impact on their lives.³¹¹

This means it is important for clinicians and the Tribunal to acknowledge this role and sensitively explore with the consumer the implications of their child attending the hearing. This exploration should involve gaining an understanding of the roles and responsibilities children currently have (and have had in the past), the kinds of supports the child has inside and outside of the family and the status of the parent-child relationship.³¹² To safeguard the wellbeing of the young person, clinicians should consider arranging for them to receive the support of a trusted adult or advocate, particularly for the period their parent is unwell. Young carers should also be directed to appropriate support services.

Chapter 7 of this Guide contains a section on conducting a hearing with a young person present as a carer or support person for the consumer.³¹³ It includes considerations the Tribunal needs to weigh up when deciding whether it is appropriate for the young person or child to be present. To recap, these factors include: the age of the young person; their role in the life of the consumer; the possible content of the information that will be presented at the hearing; the consumer's and the young person's expressed wishes; and the treating team's view based on their knowledge of the situation and family roles. Finally, the Tribunal may need to consider approaches to the hearing that might enable the young person to be present for most of the discussion but absent when some matters are being explored.

9.6 Aboriginal and Torres Strait Islander carers

Few people from Aboriginal and Torres Strait Islander communities identify as carers although many have significant care responsibilities.³¹⁴ The concept of family is often more broadly defined in Aboriginal and Torres Strait Islander cultures.³¹⁵ This and a range of other cultural, historical and social factors affect support people and consumers who identify as Aboriginal or Torres Strait Islander. The caring role undertaken by Aboriginal and Torres Strait Islander people will be the subject of separate, more detailed, consideration as part of the Tribunal's Reconciliation Action Plan.

Section 1 Guidance for mental health services

9.7 Pre-hearing preparation

Summary

- Mental health services are best placed to initiate a discussion with a consumer about family, friends, carers and other support people participating in Tribunal hearings.
- As a first step, it is important to discuss with the consumer who the important people in their life are and to record the right people in the CMI/ODS state-wide database. This will ensure the Tribunal can notify them of and communicate with them about hearings.
- Managing support people's expectations is another important part of preparing them for Tribunal hearings. The Act enshrines the role of carers but also balances their needs against other considerations, such as a consumer's right to a fair hearing.
- Consumers have a broad right to access documents and hear information that relates to them. This means that support people cannot: (i) send documents to the Tribunal in confidence; (ii) be guaranteed that records of conversations they have with the treating team will remain confidential; and (iii) access documents that the mental health service prepares unless the consumer agrees.
- In addition, although the Act requires the Tribunal to notify carers and nominated persons of hearings, a consumer is entitled to object to their participation. This Chapter outlines strategies the Tribunal may use to accommodate everyone's concerns. However, in some cases it may decide that consumer participation must be prioritised.
- Finally, the Act does not allow carers to request a statement of reasons or seek a review of the decision by the Victorian Civil and Administrative Tribunal.

Families and carers are a valued resource in mental health care and yet their incorporation into the process of health care varies. Greater involvement of those who may provide support for clients needs to be considered. This goes beyond what the tribunal can do, and also involves how clinical services contribute and address carers and other social supports the client may rely on. [...] [C]arers felt they were often excluded from the health services context. Carers were involved in hearings in only a minority of cases, either because they were not properly informed about the tribunal process or the process was not able to fit around their other commitments – although some carers felt they did not need to be involved.³¹⁶

As the above passage from Terry Carney et al indicates, the attendance and meaningful participation of carers in hearings to a large extent depends on groundwork completed well before the hearing. In fact, it is possible to avoid many common conflicts and questions that arise on hearing day if the consumer and their

family, friends and carers and other support people understand the Tribunal's role and have discussed who will participate in the hearing and their respective perspectives before the hearing. Advance statements can also be a useful mechanism for consumers to communicate their views and record their preferences with respect to the engagement of support people.

The Tribunal can provide information about hearings and common issues (such as access to documents) in the form of brochures and website information. However, the mental health service treating the consumer is best placed to initiate discussions about participation in Tribunal hearings. Understanding the nature of a consumer's relationships and the extent of support people's involvement in the consumer's life is the foundation for a collaborative partnering between the consumer, their support people and their treating team for Tribunal hearings.

This section is intended to clarify the legal framework relevant to the participation of carers in hearings as well as provide guidance on how mental health services can initiate discussion with consumers and their support people about Tribunal hearings. The Tribunal does not purport to be the source of authority on how clinicians can best initiate these discussions. Rather, the guidance on this, especially in [section 9.7.3](#), heavily draws on guidance prepared for services by other organisations, particularly the Bouverie Centre, the Chief Psychiatrist, Mind Australia and others.

9.7.1 Establishing and recording the important people in the consumer's life

As a first step, ask the consumer who the important people are in their life. Guidance on how to do this is contained in [section 9.7.3](#). This section focuses on the importance of ensuring the right people are recorded as carers and nominated persons in the state-wide electronic database maintained by designated mental health services across Victoria. These persons (and others not listed here) are sometimes referred to by the short-hand 'compulsory notifications' because they are required to be notified at various stages of the compulsory treatment process, including when Tribunal hearings are scheduled.³¹⁷

The Tribunal can only communicate with carers who are listed as compulsory notifications in this database. The Tribunal does not have the ability to enter this information itself (it has read-only access) and relies on mental health services to do so.

For this reason, services should ensure they familiarise their staff with how to correctly identify compulsory notifications (noting there may be more than one person who the consumer identifies as a carer). For example, a parent of an adult consumer who the consumer also identifies as their carer should be listed under 'carer' rather than 'parent' as the Tribunal must only send notifications to those listed as parents when the consumer is under the age of 16. On the other hand, if the consumer's parent is a nominated person, it would be appropriate to list them.

The *Practical Guide for Working with Carers of People with Mental Illness* by Mind Australia and other organisations reinforces the importance of recording this information:

*The inclusion of a carer nomination form as a regular part of all documentation acts as a reminder for you throughout all stages of care that it should be completed and updated on a regular basis ...*³¹⁸

It is crucial that you identify who the carers are, have consulted with them, and understand what they might need from you.³¹⁹

The Chief Psychiatrist's guideline also emphasises the importance of asking the consumer who the important people in their life are and the nature of their involvement and relationship. Once the important people in the consumer's life are identified, it is part of the mental health service's responsibility to collect, review and maintain their contact information.³²⁰

9.7.2 The role of carers under the Act: balancing various considerations

As well as recognising the important role of carers in the mental health principles, the Act requires the Tribunal to:

- notify carers and nominated persons of upcoming Tribunal hearings³²¹
- during the hearing, to the extent that is reasonable in the circumstances, have regard to the views of a carer if the Tribunal is satisfied that making an Order will directly affect the carer and the care relationship³²²
- send carers and nominated persons a copy of any Order it makes at the hearing.³²³

At the same time, the Act needs to balance the needs of carers alongside other considerations, such as a consumer's right to a fair hearing. This means situations can arise where either or both consumers and carers are not entirely happy with how the Act seeks to accommodate their interests. Managing support people's expectations is an important part of preparing consumers and carers for Tribunal hearings. To assist services in this task, this section sets out explanations for common areas of confusion for carers.

Support people's wish to provide information in confidence and the consumer's right to a fair hearing

An aspect of the Act that is often confusing for support people and consumers is a consumer's right to access documents, such as their clinical file, before their hearing. Consumers have the right to see documents in connection with a hearing so they know what the clinical records and other information says about them.³²⁴ This helps them prepare for the hearing and respond to issues raised in the documents. This is an important aspect of procedural fairness which the Tribunal must apply at hearings.³²⁵

The only exception to the consumer's right to access documents before a hearing is when their authorised psychiatrist applies to the Tribunal to deny the consumer access to a document or certain documents. A consumer is not able to attend a preliminary hearing to decide an application to deny access to documents. The Tribunal will deny the patient access to documents if satisfied they may cause serious harm to the patient or another person.

Problems can arise when family, friends, carers or other support people want to give the treating team or the Tribunal information they do not want shared with the consumer, and do not want the consumer to be made aware the support person wanted the information kept confidential. Usually this is because they are concerned

about how the consumer might react and of a negative impact on their relationship. This is a difficult issue because a consumer's broad right to access documents (subject to the limited exception mentioned above) and hear information that relates to them means that carers cannot:

- send documents to the Tribunal in confidence (in other words, without the consumer reading the document)
- be guaranteed that any records of conversations they have with the treating team are confidential and can never be revealed to the consumer
- access documents the mental health service prepares unless the consumer agrees. (To this end it can be worth asking the consumer if they are happy to give their support person access to these documents.)

These and other common issues that arise with respect to access to documents are summarised in a separate Tribunal publication available on our website and entitled 'Access to documents in Mental Health Tribunal hearings: Overview and Frequently Asked Questions'.³²⁶ There is also a one-page document directed to consumers and carers entitled 'Your right to access documents before your Tribunal hearing' available on our website.

It is particularly important that treating teams manage the expectations of support people by not promising or guaranteeing that information carers provide will never be shared with the consumer. To clarify, services can make an application to deny access to a document or certain documents, but it is the Tribunal that decides if the consumer can see the document.

The fact that consumers may be able to access information family members have provided is a powerful argument for careful and respectful documenting (avoiding any inflammatory language) of conversations with families and carers in the clinical notes.³²⁷

Participation in hearings

This is another area where the Act seeks to strike a balance. The Act obliges the Tribunal to notify carers and nominated persons of hearings. This reflects the recognition that in the vast majority of matters their participation will be invaluable and not controversial. At the same time, a consumer is entitled to object to the participation of their nominated person or carer. The Act does not require the Tribunal to allow such objections automatically – each case needs to be considered individually. [Section 9.8](#) below outlines strategies the Tribunal may use to manage such situations so as to accommodate everyone's concerns as far as possible. However, in some cases it may decide that consumer participation has to be prioritised.

After the hearing

Carers and nominated persons who have been notified of a hearing will also be provided with a copy of any Order made at the end of that hearing. This will happen whether or not they attended and participated. Consumers can request a written explanation for the decision made by the Tribunal in their hearing (a 'statement of reasons') and apply to the Victorian Civil and Administrative Tribunal (VCAT) for a

review of the decision. However, the Act does not allow carers to request a statement of reasons or seek a review before VCAT.³²⁸

9.7.3 Guidance on preparing consumers and support people for Tribunal hearings

Summary

- Mental health service staff should discuss the possible involvement of support people well before any Tribunal hearing.
- The discussion could focus on potential benefits of a consumer's family and support people participating but also address any concerns they may have. The Chief Psychiatrist's guideline and other resources can help with exploring sensitive issues.
- Following discussion with a consumer, the treating team can reach out to family and support people to help them prepare for the hearing. Part of this will be clarifying the issues the hearing will likely focus on and identifying questions or discussions that support people would prefer not to be a part of, and have strategies in place for dealing with these if they come up.
- If a consumer or their family and support people are reluctant to participate in a Tribunal hearing, it can be helpful to 'leave the door open' for participation in the future. This involves checking in with everyone before every hearing.

An important part of preparing for a hearing is engaging and negotiating with a consumer about the possible involvement of family, carers, friends and other support people at the hearing.³²⁹ Ideally, mental health service staff should start this discussion well before any Tribunal hearing. The discussion could focus on the potential benefits of a consumer's family participating but also address any concerns of the consumer. This may involve acknowledging that at times the consumer may have been in conflict with their family or carers and there may be reasons why their participation is not appropriate.

Example of discussing family's participation with consumers

'John' tells his treating team he doesn't want his partner, Sue, to be involved in discussions with the treating team or in Tribunal hearings. Adopting a curious approach, the treating team could ask John what his concerns are and what excluding his partner from these processes could mean for his relationship with her and her caring role. Alternatively, or as well, the treating team (and later the Tribunal) could use circular questions about what John thinks Sue might say. This could lead to exploring the pros and cons of Sue being involved.

One of the pros of Sue participating that could be worth making John aware of is that, without Sue's input, the Tribunal might not have all the relevant information before it to make the best decision. For example, if John is proposing to live with Sue but the Tribunal doesn't hear Sue's perspective on this, it may be difficult for the Tribunal to decide there is a less restrictive way of treating John or that he could be treated in the community (for example living with his partner) rather than in hospital.

One of the cons could be that John is concerned Sue will say that she prefers him to be on higher doses of medication so he can sleep through the night and not disrupt her own sleep. However, John finds that too much medication makes it difficult for him to think properly and get things done and ultimately delays his recovery.

As the example of John indicates, it is helpful for the treating team to be curious about a consumer's reasons for not wanting to include family or support people, to explore concerns and their context and the arguments for and against them being included.³³⁰

It is also important a consumer is aware that, if a carer wants to attend a hearing despite the consumer's opposition, it is up to the Tribunal to make a final decision about whether a carer can attend and on what basis. This means service staff should let carers know the Tribunal makes this decision. For this reason, service staff should be careful not to tell carers not to come solely on the basis the consumer doesn't want them to attend.

Addressing the issues the consumer is comfortable sharing with support people

It is important to clarify what a consumer considers can and can't be shared.³³¹ For instance, there may be a particular issue that John doesn't want to discuss with the Tribunal in front of his partner. John might not want Sue to hear about past trauma. But John is otherwise happy for Sue to be involved in discussions with the treating team and in Tribunal hearings.

Finally, clinicians can also explore options with a consumer about how they can best communicate with them and their support networks.

Reaching out to support people before the hearing

Once the treating team has clarified a consumer's views and preferences about their support people attending, the team should reach out to them to help them prepare for the hearing.

Part of this discussion will be to clarify the issues the hearing will likely focus on and the limits on what information can remain in confidence and the other matters identified.

Another part will be to clarify questions or issues that support people would prefer not to answer or be part of and have strategies for dealing with these if they come up. For example, this might mean that support people leave the hearing while these matters are discussed.

If support people are reluctant to participate in a Tribunal hearing or the consumer doesn't want them to attend, it can be helpful to 'leave the door open' for participation in a future hearing. This involves checking in with the consumer and their support people before every hearing to see if their views have shifted.³³² This may also be the opportunity to provide information on the support services available to family, friends and carers.

9.7.4 Sometimes family participation in hearings is not appropriate

It is also important to be aware there are circumstances when it will not be appropriate or helpful for particular family members or other support people to be involved in a consumer's treatment and care. These circumstances include where the consumer is a past or current victim-survivor of family violence or abuse at the hands of a family member.³³³ As a corollary in these cases it would not generally be appropriate for them to participate in Tribunal hearings.

Once again, it is helpful if the treating team and the consumer discuss any particular red flags for family or support person involvement before any Tribunal hearing as these issues are difficult to negotiate on the day of the hearing. The Chief Psychiatrist's guideline suggests that sensitive enquiry about the important people in a consumer's life includes discussing 'any problems, concerns, conflict or other issues such as trauma, abuse or family violence' and refers to the Chief Psychiatrist's family violence guideline and resource kit.³³⁴ The Blue Knot Foundation has also published a guide on talking about trauma for health and other service providers.³³⁵

Section 2 Guidance for Tribunal members

9.8 Deciding who can participate and the terms of their participation

Summary

- The Act requires the Tribunal to have regard to the views of carers where making an Order will directly affect the carer or care relationship, but only to the extent it is reasonable in the circumstances.
- The Tribunal makes the decision about whether carers and family can participate in the hearing on a case-by-case basis. In cases where a consumer is strongly opposed, the Tribunal should have regard to the overall circumstances to determine what is reasonable. This is often not an 'all or nothing' scenario.
- Strategies the Tribunal can use to negotiate the participation of support people (or to bring their views into the hearing even when not present) include:
 - reassuring the consumer their support people's views do not carry more weight than their own and that the consumer's own views and preferences are central
 - seeing how the consumer feels about restricting their carer's participation to part of the hearing only
 - agreeing to parameters of support people's participation; for example, only speaking if the consumer agrees, and confirming this at the start of the hearing
 - asking circular questions to 'virtually' bring carers into the room even when they're not there; for example 'If your mother were here today, what do you think her opinion would be?'
 - acknowledging that some issues of concern may be outside the scope of the Tribunal's direct powers but the Tribunal may be able to facilitate a discussion about possible ways to address these concerns.

Common scenarios when consumers and carers are not prepared for the Tribunal hearing

'Karen's' parents are listed as her carers in the state-wide database and have received a Notice about Karen's upcoming Tribunal hearing. They turn up at the service for the hearing at the appointed time, but Karen becomes distressed and tells her treating team and the Tribunal she doesn't want her parents at the hearing.

'Peter's' sister attends the hearing but Peter himself is not there. No one knows whether Peter would be happy for his sister to attend his hearing without him.

These scenarios are more likely to arise when no preliminary conversations have occurred with a consumer or their support people about the Tribunal hearing and who should participate. How should the Tribunal handle these situations, bearing in mind there is much less time to deal with them than in the preparatory phase before the hearing?

As noted above, the Act requires the Tribunal to have regard to the views of carers where making an Order will directly affect the carer or care relationship, but only to the extent this is reasonable in the circumstances. Carers cannot insist on participating in a hearing against a consumer's wishes but nor does the consumer have the 'final say'.

In some cases, the Tribunal may consider it appropriate and necessary to talk to the consumer's support people despite the consumer's wishes (or where these wishes are unknown). In cases where consumers are strongly opposed to this, the Tribunal will have regard to the overall circumstances to determine what is reasonable. It is often not an 'all or nothing' scenario. For example, one option is limiting the participation of support people to part of the hearing or to a subset of the issues being discussed.

In this section we explore techniques the Tribunal can use to negotiate with the consumer about support people participating in the hearing and the scope of any participation.

9.8.1 Techniques the Tribunal can use to negotiate the participation of support people in hearings

The overarching principle is one of getting from 'what' to 'why'; that is, exploring the underlying reasons why the consumer might not want their support people to participate. Strategies include:

- Ask the consumer what their concerns are about the person participating. If their concerns are about particular issues (such as drug taking), the Tribunal could explore how the consumer feels about restricting that person's participation to part of the hearing only. However, it is important to be sensitive to the fact the consumer may find it too distressing or uncomfortable to disclose the reasons why they don't want their support people to participate.

- Emphasise how important hearing from support people can be to the Tribunal's decision and how what they have to say could help identify options and assist the Tribunal to decide the least restrictive means available to receive immediate treatment.
- Be clear about any agreed parameters of the support person's participation, such as the person being unable to speak to the Tribunal in confidence or the family member can only speak if the consumer agrees.

On the other hand, it is important to recognise there may be situations where a consumer's feelings about the involvement of support people may not be able to be reconciled with the Tribunal's need to hear from support people to make its decision.³³⁶ Where possible, the Tribunal should have a transparent discussion with the consumer about this. However, members must be sensitive to the fact the relationship between a consumer and family member may involve a power dynamic and underlying issues (including trauma and abuse) that mean the consumer is not comfortable in saying they don't want their family member to be at the hearing or the reasons why.

It is important the Tribunal establish a safe environment to address these issues and the consumer doesn't feel pressured into passively acquiescing to family members participating in the hearing. For example, the Tribunal should ensure that family members are not in the room while their potential participation is being discussed. (Similarly, there may need to be separate or 'shuttle' discussions with the consumer's support people restricted to the subject of their participation in the hearing).

An experienced Tribunal member summarised her approach to negotiating participation in the following way:

In my standard opening comments, if family members are in attendance, I usually ask the patient if it's okay for us to ask the family member/s some questions, also indicating that it is usually very helpful for us to hear from them.

One option where the patient does not want them to participate is to negotiate that the family member(s) attend but don't speak or only if the patient agrees. That way, after the hearing has been going for a while and if the patient can see that we are listening to what they say and are feeling respected, they are likely to say okay. Patients are usually very anxious at the start; over the course of the hearing things become a little easier to negotiate.

Another strategy is to assure consumers that in instances where they have some reservations about the Tribunal hearing from family, they will have an opportunity to comment on the family member's evidence (a right to respond essentially). Setting out a clear process at the outset almost always helps.

Sometimes a consumer's wish to exclude their family could indicate they think their family would agree with the treating team. However, it is important to test this assumption during the hearing. One way of doing this is to ask circular questions to uncover information and deepen understanding between participants. These questions can also be very useful to (virtually) bring carers into the room when they are not present. For example, the Tribunal could ask:

'If your mother were here today, what do you think her opinion would be?'

'Do you talk to your father about your side effects? What suggestions does he have?'

'How do you think your partner would feel about you going back home to live after this hearing?'

At the same time, Tribunal members should also reassure the consumer their support person's views do not carry more weight than their own and that the consumer's own views and preferences are central.

9.8.2 Commencing the hearing

At the start of a hearing it is important to orient hearing participants, including support people, to the structure of the hearing, negotiating a safe space and the conduct of participation.³³⁷ For example, the Tribunal could thank support persons for attending the hearing and emphasise how helpful their input can be to the Tribunal's decision. At this stage, the Tribunal could also confirm and clarify the scope of participation (for example, if it is agreed they will only participate in part of the hearing or only speak if the consumer agrees and so on).

The Tribunal can at this stage clarify the issues it needs to focus on and how the input of support people may be helpful. At the same time, it could also acknowledge that hearings can be difficult for family members, friends and carers and they should feel free not to comment on particular issues (see more on this below). For instance, in most hearings it will be relevant to focus on what support family members are able to give the consumer and the issues from the family's perspective that may be hampering them from providing that support, which may of course include their own needs and circumstances.

At this point the Tribunal could also acknowledge that while some issues of concern to the consumer and their support people may be outside the scope of the Tribunal's direct powers, the Tribunal may be able to facilitate a discussion between hearing participants (including the treating team) about ways to address these concerns. Some of the most solution-focused hearings occur when all participants in the hearing use the Tribunal process as a focused opportunity to share their own perspectives and listen to the perspective of others in such a way as to be involved and engaged in the outcome.

The case study of 'Craig' below illustrates how some of the techniques described in this section can work in practice, particularly how the Tribunal can negotiate with participants to set parameters and ground rules to facilitate consumers and their family members participating in a hearing and discussing issues in a constructive, positive way.

‘Craig’

‘Craig’ was in his early twenties and lived with his parents. He had initially been placed on an Inpatient Temporary Treatment Order that had been varied to a Community Temporary Treatment Order six days before the Tribunal hearing. Craig was diagnosed with first episode psychosis following his return from interstate earlier this year. The previous six to nine months were characterised by Craig’s behaviour becoming increasingly erratic and out of character (including alcohol and substance abuse, risk-taking behaviours and sleeping rough). Craig and his parents attended the hearing.

The Tribunal was advised that Craig did not want his parents to participate in the hearing and that Craig’s parents had a letter they wanted to give to the Tribunal. The Tribunal encouraged everyone into the hearing room to discuss hearing arrangements and their preferences.

After introductions, the Tribunal explained the legal framework and process. The Tribunal asked Craig’s parents about the letter they had for the Tribunal and whether Craig had seen it – he had not. The Tribunal explained that if it was to have that information, fairness required that Craig should be aware of it too. Craig’s parents agreed to this but the Tribunal suggested they keep the letter for the time being while all participants considered how the hearing could best proceed.

Following its explanation about the hearing and Tribunal processes and the importance of taking into account all perspectives before making its decision, the Tribunal asked Craig if he was prepared to have his parents remain in the hearing so they could tell the Tribunal what they wanted it to know. He agreed. The Tribunal asked Craig’s parents to keep their letter (which neither the Tribunal nor Craig had read) and simply talk to the Tribunal to the extent they felt comfortable.

Craig provided his evidence clearly and thoughtfully, and listened calmly as his parents both made brief comments, including some things they knew Craig disagreed with. After considering all the information before it, which had been heard by everyone involved, the Tribunal made a CTO for six months.

9.9 Encouraging constructive participation during the hearing

Summary

- Practical tips for facilitating constructive participation by family members, friends and carers include 'checking in,' redirecting the focus to the salient issues and respectful interrupting.
- Tribunal members must be aware of inviting support person participation without putting them 'on the spot' and potentially jeopardising their relationship with the consumer.
- It can be useful to preface questions to support people with an acknowledgement that it might be difficult for them and that they can say as much or as little as they want (or just be there to support the consumer).
- When tension is evident or support people express frustration, the following strategies can help.
- Ask about the consumer's positive attributes, for example: *'When things are going well, what are they like?'*
- Acknowledge, normalise and validate the range of feelings they may express. But this doesn't necessarily mean agreeing with their point of view.
- Reframe issues and highlight what participants have in common. For example: *'We'd all like Claudia to get better and get out of hospital as soon as possible'.*
- Ask participants whether they can put aside or 'park' the issue generating conflict so the Tribunal can refocus on the matters that need to be addressed at the hearing.
- Comment on any strengths or positive behaviours.
- Check in with the consumer to see how they are reacting to what support people are saying.
- Facilitate a dynamic conversation between the consumer, their support people and their treating team (known as a triologue). This may involve inviting participants to directly respond to what others have said. For example: *'We've just heard John say how [...]. Is this something you've heard him say before? How might this affect your understanding of John?'*
- Refer or redirect carers to other resources or services.

Once the hearing is underway, another challenge is encouraging support people to participate constructively and without damaging their relationship with the consumer while maintaining their focus on the consumer and the issues that need to be addressed. Depending on the issues to be discussed and the 'mood' on the day, this could simply be about encouraging family members to give their perspective or about facilitating a richer, more SSFC or family conference style of discussion. Sometimes

it may also be about discouraging excessive and possibly counter-productive contributions from family members.

This section provides guidance on how to facilitate support persons participating constructively in hearings and how to handle common issues that arise.

Practical tips for facilitating constructive participation during hearings

Specific techniques used to facilitate SSFCs can also be adapted for use in Tribunal hearings. For example, 'checking in' is one technique the Tribunal can use if a support person does not seem to be engaged in the hearing.³³⁸ For example:

'Jane, I know you don't have a lot to do with your brother, but I'm interested to hear your understanding of what's happening for him and the family at the moment.'

Similarly, a technique from SSFCs is keeping things on track so that issues which need to be discussed remain the principal focus. For example:

'Can we bring the focus back to X now?'

Related to this is the time-limited nature of the SSFC which applies equally to Tribunal hearings. This provides a good incentive to be direct. For example:

'We don't have a lot of time left, so can I be direct with you and share some of my thoughts about what has been said?'

Respectful interrupting is covered in [section 5.4.2](#) of this Guide. It can be a particularly important technique in hearings where there is conflict, or the discussion is moving too far away from the issues the Tribunal needs to address. Examples of respectful interrupting include:

'Can I get you to hold that thought for a moment while I check something with you?'

'Could we hit the 'pause button' on that for a moment? We are aware that we haven't heard much from Angela yet and I was just curious as to what she thought about what is being said?'

An experienced Tribunal member summarised her approach to facilitating family, friends and carers participating constructively in hearings which draws on some of these techniques:

'One of my strategies is to explain that I understand everyone has a lot to tell us but it's important that everyone gets to speak uninterrupted and that everyone will get a chance to talk. I also try to emphasise that our primary focus is on compulsory treatment as sometimes family members expect to participate in a family conference type situation. It is also useful to be empathetic and express an understanding that this is an emotional experience for all concerned.'

'I think it's important to prepare carers about the purpose and limitations of the hearing. As the chair we have to balance the varying dynamics and ensure that family members don't feel they are being short-changed whilst at the same time making sure that the patient is not aggravated by their attendance and contribution. We also have to be careful not to jeopardise relationships by putting family members on the spot about whether they think

the patient is ill, needs treatment or compulsory treatment. It is a very delicate balance.

9.9.1 Inviting participation without putting support people ‘on the spot’

A common source of anxiety for support people during Tribunal hearings is openly answering questions about the consumer for fear of jeopardising their relationship with them. This is particularly the case if their perspective of how the consumer is going is different from the consumer’s take on the matter.

A carer quoted in research by Carney et al highlights this common dilemma:

‘I was asked how I thought A was getting on and if you’re asked that sort of question in front of somebody who’s mentally ill and you’re trying to nurse back to health, you’re not going to say I think she’s totally lacking insight and really desperate. So both her doctor and I said, ‘Look she’s really trying hard and she’s hoping to get back to Burnley next year to do a horticultural course she’s had to abandon this year.’ I think we were probably relatively positive because you’ve got to think of your relationship with the person that you’re dealing with and I’m absolutely certain that her doctor felt that way.’³³⁹

How can the Tribunal deal with this situation? First, it’s important to have checked in with the consumer at the start of the hearing if it’s okay to hear from their support people. Negotiating and deciding who can participate in the hearing and the terms of the participation is discussed earlier in this Chapter. Once the hearing is underway, it can be useful for members to preface any question they ask of family members with an acknowledgement that it might be difficult for them, such as:

‘We appreciate that Tribunal hearings aren’t always easy. So, you can tell us as much or as little as you want or you can just be here as a support.’

If a support person appears anxious and hesitant when a question is asked, it is important not to push the point. In these circumstances, it can be helpful to say: ‘Let’s leave that for now’ and move onto another matter. It may be possible to gently re-visit the issue later, but this won’t necessarily be the case and it is important not to subject clearly uncomfortable family members to probing questions. This is consistent with SSFC principles which state that, while family members and the consumer are encouraged to raise issues important to them, they should not feel obliged to share information they are not comfortable discussing.³⁴⁰

Another helpful line of questioning to open discussion with support persons where tension is evident is to ask about the consumer’s positive attributes. For example:

‘When things are going well, what are they like?’

This technique generally leads to a relieved and positive response which can encourage more open discussion on other topics.

The Tribunal needs to be sensitive to the potentially difficult situation a support person finds themselves in during the hearing and to adapt their approach if necessary. This involves considering any evidence of risk of harm as well as an astute reading of the atmosphere and dynamics in the room on the day. If a consumer and support persons are well prepared for the hearing and the consumer is happy for their family to be involved and has developed confidence in the process,

it is more likely that support people will feel comfortable participating openly in the hearing.

9.9.2 Responding effectively to frustration and complaints during the hearing

Family members and other support people can experience burnout from dealing with their relative's mental illness. Sometimes this can affect how carers behave in Tribunal hearings. For example, members report that in some hearings, carers effectively adopt the role of a 'witness for the prosecution', by dwelling on everything that has ever gone wrong. They may express the view the consumer should 'never come off the Order'.

Related to this can be a carer's unhappiness with the mental health system. For example, carers may occasionally use the hearing as an opportunity to 'sheet home' the shortcomings of the public mental health system to the treating team members present at the hearing.

In responding to complaints and frustration in a hearing, it is useful to bear in mind that families are 'essentially motivated by survival rather than malevolence' and are usually attempting to solve problems.³⁴¹ When family members behave in seemingly unproductive ways, an appreciation of the family situation can help treating teams and the Tribunal to address this behaviour more effectively.³⁴² Strategies for dealing with support people's frustration

It can help to acknowledge, normalise and validate the range of feelings that family may express.³⁴³ For instance, the Tribunal might acknowledge how bad things are and that everyone would like things to be better.³⁴⁴ This doesn't necessarily mean agreeing with a support person's point of view.³⁴⁵ It can mean asking if people can agree to disagree about some things.³⁴⁶ An example adapted from the SSFC model is:

Carer: 'The service has done nothing for Jack.'

Possible Tribunal response: 'Frank, it sounds like you're pretty frustrated with the treating team and feel they haven't been able to help Jack in the way you were hoping.'³⁴⁷

This is similar to a technique described in [section 4.5.1](#) of this Guide, namely paraphrasing or using your own words to repeat back to someone else what they have said.³⁴⁸

Reframing can be another useful technique to defuse difficult or stuck interactions. For example, the Tribunal could recognise a carer who is very energised and dominant in a hearing as a passionate advocate who cares for their loved one. Finding and highlighting points of commonality where possible can be useful.³⁴⁹ For example:

'Although we have heard different views about your treatment, we have heard everyone here say they want to help you with your aim of staying out of hospital / becoming voluntary / gaining employment / reducing substance use.'

'We'd all like Claudia to get better and get out of hospital as soon as possible.'

Another technique is to ask family members and the consumer if they can put aside or ‘park’ the issue generating conflict so the Tribunal can refocus on the issues that need to be addressed in the hearing.³⁵⁰ In these situations, the Tribunal can also use some of the interrupting or redirecting techniques mentioned above.

A hearing may be an opportunity to listen to the experiences of families and ‘comment on strengths, particularly positive behaviours or attitudes demonstrated in adversity’.³⁵¹ This is essentially the technique of supporting or acknowledging and identifying with a person’s situation described in [section 4.5.2](#) of this Guide. An example from the SSFC context is:

‘It sounds like it has been really tough trying to keep the household going while giving John that extra support you talk about. How have you managed to do both?’³⁵²

Finally, it is important to check in with the consumer and see how they’re reacting to what support people are saying. In the words of one experienced member:

‘I make sure to observe the patient’s body language and reaction to the evidence from carers and sometimes check in with them to reassure them that their welfare is important in the face of confronting disclosures. I might say, “How are you coping with this, Tim? Just remember, we’ll give you the chance to respond to whatever your mum is telling us today.”’

Use of triologue techniques

A ‘trialogue’ is a dialogue between the consumer, their support people and the service. It has been described as a method:

to bring together the perspectives of consumers, family members/carers and mental health practitioners. It provides a facilitated safe space to reflect on relevant, topical, key and difficult issues (often difficult to discuss and openly acknowledge) in mental health settings.

[...]

Two important outcomes of Triologue are that it shapes a space that enhances realistic, honest and inclusive ways to communicate and inform as well as offering all stakeholders greater and equal opportunity to actively participate and contribute.³⁵³

Triologue is not specifically a problem-solving method but it can start the process to discuss problems and think about potential solutions. In this sense it is consistent with solution-focused hearings that facilitate participants discussing, identifying and committing to future actions or solutions (rather than miscasting the Tribunal as the source of solutions).

In the context of hearings where there is an atmosphere of conflict and significant differences of opinion, it may be appropriate and necessary for the Tribunal to facilitate a dynamic conversation between the three key hearing participants (the consumer, their support people and the service). This may involve inviting the participants to directly respond to what the others have said.

For instance, it can be worth asking the treating team representatives to respond to an issue or idea raised by one of the other participants – ‘*what’s your view on this?*’ – rather than simply listen to them recite what is written in their hearing report.

Similarly, the Tribunal could encourage the consumer and their family, friends and carers to tell the treating team directly what their concerns are. For instance:

'The treating team are also listening to you today. How can they improve on the treatment plan from your perspective?'

'Can the treating team offer you support as there are helpful resources available for carers?'

'We've just heard John say how [...]. Is this something you've heard him say before? How might this affect your understanding of John?'

Referral or redirection to other services

Finally, depending on the nature of the family's concerns, it can also be useful to refer them to other resources such as carer consultants, organisations such as Tandem and the National Carer Counselling Program³⁵⁴ that can provide support, and referral to carers as well as individual advocacy, or to avenues of complaint such as the Mental Health Complaints Commissioner. It is worth noting that services also have access to carer support funds to assist family and carers attend hearings and other meetings where they may need to take time off work. However, it is important not to make definitive statements about specialist interventions (including SSFCs) which may not be available at particular services.

9.10 Concluding the hearing

Summary

- Asking an open-ended question before deliberating on its decision can help the Tribunal to ensure everyone has a final chance to have their say.
- The conclusion of a hearing is an important opportunity to summarise any actions participants have agreed to take and give a sense of 'where to from here'.
- This can give the consumer and their support people concrete steps to take that will hopefully lead to the consumer being able to be treated less restrictively in the future.

Before deliberating on its decision, the Tribunal could ask an open-ended question about anything else that participants want to mention. This helps ensure everyone has a final chance to have their say and be heard. For example, the Tribunal might ask participants:

'Is there anything we haven't covered that you wanted to mention?'

*'Are there any questions about what we've discussed today that haven't been answered yet?'*³⁵⁵

Once the Tribunal has deliberated, it needs to verbally deliver the reasons for its decision.³⁵⁶ As well as explaining why the criteria in the Act are met or not met, the conclusion of the hearing is an important opportunity to summarise any actions that participants have agreed to take and to provide a sense of 'where to from here'.³⁵⁷

This could focus on confirming what a consumer, their support people and treating team have identified over the course of the hearing as strategies that could mean the criteria for a Treatment Order are no longer satisfied.

This can provide a sense of hope that, if the Tribunal decides to make a Treatment Order today, the consumer may not need to be on an Order in the long term. It also gives the consumer and their support people concrete steps to take that will (hopefully) lead to the consumer being able to (continue to) access treatment on a voluntary basis in the future.

The conclusion of the hearing is also a good time to mention that the consumer might like to make an advance statement or formally appoint a nominated person (if they haven't done so already). These are both important instruments of supported decision making under the Act.

Finally, if the discussion has raised issues beyond the scope of the Tribunal's powers and expertise, it may be useful to summarise any future steps (including links to other programs) that the consumer, their support persons and the treating team agreed to during the hearing. For example:

'Today some issues were raised that went beyond the scope of what we were able to focus on today. But it was positive that everyone agreed to explore the idea of a single session family consultation to discuss strategies to address some of the day-to-day issues that come up for you as a family.'

'Rohan, you expressed frustration today about the lack of communication you've had from the treating team about Sarah's treatment. The treating team have heard your concerns and have agreed to a regular catch up with you and Sarah to discuss your concerns, particularly around changes to her medication and what side effects to look out for. They've undertaken to touch base with you about the best timing of these meetings.'

²⁹⁰ As noted in Carney et al, above n 4, '... having the family or friend most involved with the consumer's situation engage with the clinical services, and be seen as a useful contributor to their care and treatment, may alter the outcome of the hearing,' p. 221.

²⁹¹ Royal Commission interim report, above n. 45, p. 239.

²⁹² See Bouverie Centre, module on 'Introducing the Nominated Persons and Carer Provisions,' <https://www.bouverie.org.au/module/>.

²⁹³ Bouverie Centre, 2016, *From Individual to Families, A Client-centred Framework for involving families*.

²⁹⁴ Department of Health and Human Services, 2018, *Working together with families and carers, Chief Psychiatrist's Guideline*, State Government of Victoria.

²⁹⁵ Rhys Price Robertson, Angela Obradovic and Brad Morgan, 2016, 'Relational recovery: beyond individualism in the recovery approach' *Advances in Mental Health*, October 2016, p. 2. In another publication, Price Robertson et al point out: 'recovery occurs in social contexts. For many individuals experiencing mental illness, the family is the most salient context: estimates have indicated that over 50% of Australia's mental health service users have daily contact with family members ... and roughly 20% live with dependent children... [citations omitted], Rhys Price Robertson, Gemma Olsen, Helen Francis, Angela Obradovic, Brad Morgan, 2016, 'Supporting recovery in families affected by parental mental illness,' *Child Family Community Australia (CFCA) Practitioner Resource*, August 2016, <https://aifs.gov.au/cfca/publications/supporting-recovery-families-affected-parental-mental-illness>.

²⁹⁶ Mind Australia, Helping Minds, Private Mental Health Consumer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia, 2016, *A practical guide for working with carers of people with a mental illness*, March 2016, p. 10.

²⁹⁷ Chief Psychiatrist Guideline, above n 294, p. 10.

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- ²⁹⁸ Bouverie Centre, 2014, *Single Session Family Consultation Practice Manual*, Version 2, November 2014, p. 2.
- ²⁹⁹ See A Carr (2009a), 'The effectiveness of family therapy and systemic interventions for adult-focused problems,' *Journal of Family Therapy* 31(1) 46-74 and A Carr (2009B), 'The effectiveness of family therapy and systemic interventions for child-focused problems', *Journal of Family Therapy*, 31(1), pp. 3-35. Doi: 10.1111/j.1467.2008.00451.x, both cited in Bouverie Centre, *Practice Manual*, above n 8.
- ³⁰⁰ Royal Commission Interim Report, above n 45, p. 246.
- ³⁰¹ *Ibid*, p. 247.
- ³⁰² This is one of the treatment criteria the Tribunal must consider in hearings regarding Treatment Orders: see section 5(d).
- ³⁰³ Victorian Parliamentary Debates, Legislative Assembly, 20 February 2014, pp. 470, 470.
- ³⁰⁴ *Mental Health Act 2014*, section 11(1)(k) and (l).
- ³⁰⁵ *Carers Recognition Act 2012*, section 1. Care relationships include relationships where one person provides care to another because one of the persons in the relationship has a mental illness: section 4. The principles relating to carers are set down in section 7 and highlight respect, recognition and support of carers. 'Care' is defined in section 3 as 'the provision of ongoing support, assistance or personal care to another person.'
- ³⁰⁶ Bouverie Centre, *Practice Manual*, above n 298, p. 2.
- ³⁰⁷ Bouverie Centre, *From Individual to Families*, above n 294, p. 12.
- ³⁰⁸ *Ibid*, p. 14 and Bouverie Centre, *Practice Manual*, above n 298, p. 5.
- ³⁰⁹ Bouverie Centre, *Practice Manual*, above n 298, p. 3.
- ³¹⁰ Section 11(1)(k) and (l).
- ³¹¹ Ben Ilsely, Counsellor Carers Victoria and Mental Health Tribunal member.
- ³¹² A useful resource for practitioners is Rhys Price-Robertson, Gemma Olsen, Helen Francis, Angela Obradovic, Brad Morgen, 2016, 'Supporting recovery in families affected by parental mental illness', *CFCA Practice Resource*, August 2016. Guidance includes the following (at 7): 'a great way to start to encourage family recovery is to support parents to talk about how they think their children understand mental illness, and then further support them to have conversations with their children about mental illness. For some families, just the act of sharing their experiences and perspectives with each other can be a healing experience.'
- ³¹³ See [section 7.3](#)
- ³¹⁴ Carers Victoria, 2005, *Be with us, Feel with us, Act with us, Counselling and support for Indigenous carers*, Project Report by Roseanne Hepburn for Carers Victoria, February 2005, p. 7.
- ³¹⁵ See <http://www.supportingcarers.snaicc.org.au/connecting-to-culture/connection-to-family/>.
- ³¹⁶ Carney et al, above n 4, p. 291.
- ³¹⁷ Section 189 of the Act sets out the persons who are required to be notified of Tribunal hearings. Apart from carers and nominated persons, other relevant categories for important people in the consumer's life may include guardians and parents (if the person is under the age of 16). Of course, parents of older consumers may also be carers, nominated persons or guardians but will not necessarily be.
- ³¹⁸ Mind Australia et al, above n 296, p. 13.
- ³¹⁹ *Ibid*, p. 14.
- ³²⁰ Chief Psychiatrist's guideline, above n 294, p. 10.
- ³²¹ Section 189(1)(g).
- ³²² This appears in various sections throughout the Act. See, for instance: section 55(2)(e), section 93(2)(e), section 94(2)(d) and section 94A(2)(d) among others.
- ³²³ Section 195(4).
- ³²⁴ Section 191(1).
- ³²⁵ Section 181(1)(b) provides the Tribunal is bound by the rules of procedural fairness.
- ³²⁶ See, in particular: 'Can a carer or family member send confidential documents to the Tribunal that they do not wish the patient to see?' and 'What is the status of documents recording confidential discussions between the treating team and the patient's family or carer?'
- ³²⁷ Guidance on clinical note-taking is beyond the scope of this Chapter or expertise of the Tribunal. However, useful guidance on recovery-oriented language is contained in the Recovery Oriented Language Guide, above n 5.
- ³²⁸ The exception is where the Tribunal has joined a carer as a party to the hearing: section 183. This happens only rarely.
- ³²⁹ Bouverie Centre, *From Individual to Families*, above n 293, p. 14: 'There is a strong focus on negotiating the involvement of family or other social networks with the client.' See also Bouverie Centre, *Practice Manual*, above n 298, p. 5. Posing questions about the consumer's preferences for family involvement is a key element of the convening stage of SSFCs.

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- ³³⁰ Bouverie Centre, *Practice Manual*, above n 298, p. 7.
- ³³¹ Ibid, p. 8. The consumer sharing information with people they determine are significant in their life and care is an important premise of the SSFC model. In addition, negotiating with the consumer about what might be important to discuss is a feature of the collaborative nature of the SSFC model: Bouverie Centre, *From Individual to Families*, above n 293, p. 14.
- ³³² Bouverie Centre, *From Individual to Families* above n 293, p. 17: 'For a variety of reasons, not all families will opt to be included in their relative's care; however the service can keep the door open to future involvement for such families.'
- ³³³ Ibid. More detailed guidance on this issue is given in the Bouverie Centre, *Practice Manual*, above n 297, p. 15.
- ³³⁴ Chief Psychiatrist guideline, above n 294, p. 6.
- ³³⁵ Blue Knot Foundation, 2018, 'Talking about Trauma: Guide to conversations and screening for Health and other Service providers,' (Authors: Dr Cathy Kezelman AM and Pam Stavropoulos PhD). See: <https://www.blueknot.org.au/Resources/Publications/Talking-about-Trauma-For-Health-and-Other-Service-providers>
- ³³⁶ This paragraph is drawn mainly from a submission from Victoria Legal Aid, dated 27 March 2019.
- ³³⁷ See Bouverie Centre, *Practice Manual*, above n 298, p. 9.
- ³³⁸ Ibid, p. 12: 'Hearing everyone's point of view, and help them hear each other by 'checking in' with them. If some family members are silent, gently express an interest in their views. Less engaged family members can also be invited directly to contribute a valued perspective. 'Suzie, I know you don't get caught up in the tussles between your parents and Aaron, so I'm interested in your take about what's happening between them at the moment.' This section also draws on the Bouverie Centre's internal training materials on Single Session Family Consultations.
- ³³⁹ Carney et al, above n 4, p. 221.
- ³⁴⁰ Bouverie Centre, *Practice Manual*, above n 298, p. 4.
- ³⁴¹ Bouverie Centre, *From Individual to Families*, above n 293, p. 17.
- ³⁴² Ibid.
- ³⁴³ Bouverie Centre, *Practice Manual*, above n 298, p. 10.
- ³⁴⁴ Ibid, p. 18.
- ³⁴⁵ Ibid, p. 12.
- ³⁴⁶ Ibid, p. 18.
- ³⁴⁷ Ibid, p. 12.
- ³⁴⁸ See section [4.5.1: Paraphrasing](#)
- ³⁴⁹ Bouverie Centre, *Practice Manual*, above n 298, p. 18.
- ³⁵⁰ Ibid.
- ³⁵¹ Ibid, p. 10.
- ³⁵² Ibid.
- ³⁵³ Peter McKenzie, 2016, 'New Paradigm, Towards Recovery', *The Australian Journal on Psychosocial Rehabilitation*, Winter 2016, p. 34.
- ³⁵⁴ <https://www.carergateway.gov.au> also provides information on advice, services and support for carers.
- ³⁵⁵ The Bouverie Centre, *Practice Manual*, above n 298, p. 13, states it is important to check with participants whether there is anything that hasn't been talked about that should have been.
- ³⁵⁶ Section 195(2).
- ³⁵⁷ In the SSFC context, this stage is about clarifying what has been covered or achieved and what might require further action. It is also the point where the practitioner shares their thoughts or reflections on the session and summarises any agreed follow ups: Bouverie Centre, *Practice Manual*, above n 298, p. 13.

PART 4 CONSIDERING TREATMENT AND RISK THROUGH THE LENS OF SOLUTION-FOCUSED HEARINGS

Chapter 10 Constructive inquiry, clarification and reflection – the role of the Mental Health Tribunal in relation to treatment

- This Chapter explores the nature and scope of the Tribunal's role in relation to treatment.³⁵⁸ As the primary decision maker, the Tribunal decides whether or not to compel a person to have mental health treatment.
- Treatment Orders can be understood as a 'compact' with obligations on the patient (who is required to comply with treatment) as well as the treating team (who are required to provide it). For the patient to comply, they need to have a very clear understanding of what the treatment is.
- The Chapter explores how specific decisions the Tribunal must make under the Act must be informed by an understanding of the treatment that is being provided or is proposed for them. For example, the Tribunal can only make an Inpatient Treatment Order if satisfied that a person's treatment cannot occur within the community. To make this decision, the Tribunal must understand what elements of inpatient treatment are regarded as necessary at the time of the hearing and why this is the case.
- Determining duration similarly requires an understanding of the treatment to be provided. Without this, there is no logical basis for a Treatment Order of anything more than short duration
- To decide if there is no less restrictive way for a person to be treated other than with electroconvulsive treatment (ECT), the Tribunal must consider the likely consequences for the person if ECT is not performed. This is informed (amongst other things) by the person's current treatment – why it is regarded as insufficient or ineffective; any alternatives and how long it might take to provide relief and so on.
- The Chapter also explores how the mental health principles and the Charter require scrutiny of treatment and examines the parameters of the Tribunal's role or interest in treatment.
- 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.

10.1 The Tribunal and the treatment space

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.

10.1.1 The active role vested in the Tribunal

The former Board was a review body. In contrast, the Tribunal is a primary decision maker. Whereas previously it was the authorised psychiatrist (or their delegate) who made Treatment Orders, it is now the Tribunal that takes the active role of intervening to make a Treatment Order.

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, the Tribunal must understand the treatment it is compelling a person to accept, and be satisfied the treatment, understood holistically (in other words, it extends beyond medication) meets certain minimum standards, namely those 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 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 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.

'Treatment' is defined in the Act 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 to the Tribunal as well as their treating team.

10.1.2 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 – what it does and also 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. The level of scrutiny or exploration this requires will depend 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. The Tribunal has always been clear that 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 reports before hearings and provides templates to assist them to do so. The ECT report template includes 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 direct what type of ECT will be administered pursuant to an ECT Order, some might question the relevance of this inquiry. A key basis for considering the type of ECT derives from the Tribunal's obligation to explore a patient's understanding of ECT and their views and preferences about it and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes the patient would like to achieve.³⁵⁹
- (d) From this it is clear the treating team must give (or at least attempt to give) the patient relevant information about ECT and beneficial alternative treatments. This arguably includes the type of ECT proposed. For example, in order for the patient to have a view about any beneficial alternative treatments, they need to know what type of ECT the treating team is

proposing (including risks and benefits) because the likely side effect profile of a particular form of ECT may lead them to favour an alternative treatment.

- (e) So while it is true the Tribunal does not decide what type of ECT will be administered, it does arguably have a role in asking questions about the type of ECT that is proposed and taking it into consideration in determining the criteria, particularly whether or not there is no less restrictive treatment.
- (f) 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 the likely consequences of ECT not being administered, which can in turn require consideration of a broad range of matters, including (but not limited to):
 - a person's current treatment
 - why it is regarded as insufficient or ineffective
 - if 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. Rather, the point is the extent to which the Tribunal must explore the actual treatment and treatment options for a particular person.

10.2 The mental health principles

As discussed in Chapter 3, 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 the day-to-day experience of the mental health system of patients and carers (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 option, that it is recovery-oriented and 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)).

10.3 The Tribunal's obligation as a public authority under the Charter

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 after inquiring into that treatment the Tribunal has questions – or possibly some concerns – it cannot put those questions to one side or regard them as 'out of scope'. The Tribunal 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).³⁶⁰ If quality and safety is to be a foundation principle in health care, doing nothing, or adopting a 'it's not my responsibility' response to a situation where something is unclear or does not seem right, is not an option.

10.4 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 the role of Tribunal as 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). Ordinarily it would be anticipated that ECT will start 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.

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 the Tribunal's duties, functions and powers under the Act as well as certain practical realities. Most critical of these are that its involvement or intervention in relation to each individual is relatively brief, and the Tribunal does 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 – the compulsory elements as well as those that are available to a patient should they chose to accept them (such as making an application for an NDIS package)
- 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 a 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 a constructive discussion can occur about these matters. The most difficult and 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’.

Many hearings conducted by the Tribunal will involve clear, appropriately detailed and future-focused discussions about treatment, including treatment issues that may be the subject of significant disagreement. However, there remains a sizeable proportion of hearings where the information provided to the Tribunal about treatment is opaque. On these occasions, closer scrutiny is needed. This can cause discomfort, but it is simply not open to the Tribunal to ignore these matters – treatment must be explored and clarified.

10.5 Reframing issues relating to treatment to avoid confusion

The focus of discussions about the Tribunal’s role in relation to treatment has tended to be on confirming where the Tribunal does not have a role. This means there remains some uncertainty about what the Tribunal’s role actually is. While this is an area that is never going to be amenable to definitive statements, 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.

10.5.1 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 and so it isn’t a topic for discussion in hearings.

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 the patient's preferences as well as the treating team's reasons for thinking those preferences cannot be respected at the time of the hearing.

10.5.2 Dosage levels

Traditional approach: The Tribunal doesn't decide the dosage levels of medication so it needn't be discussed in hearings.

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.

10.5.3 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 isn't 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.

‘Sam’

Sam grew up in disadvantaged circumstances and has a history of trauma. His parents are now deceased and he has limited contact with his siblings. He has a diagnosis of schizophrenia and a history of chronic drug use. It is suspected that Sam may also have an acquired brain injury (ABI) but this has not been confirmed. At times of relapse he engages in criminal behaviour, including stealing and sexual offences (at the lower end of the scale but undoubtedly traumatic for those affected). Sam is extremely vulnerable and isolated, has limited ability to care for himself and is at high risk of homelessness.

Hearing 1

After several months in an inpatient unit, Sam was transferred to a Secure Extended Care Unit (SECU). At the time of the first 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. The treating team put forward two reasons:

- 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:

- Sam had not been assessed for an ABI during his six months in SECU.
- 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 discharge destination provides no rational basis for restricting leave.

Outcome of Hearing 1

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

- a revised treatment plan would be required, developed in collaboration with Sam and his legal representative
- the revised treatment plan needed to include a clear strategy for Sam’s transition from SECU
- the treating psychiatrist from Sam’s referring service would be required to participate in the next hearing to enable meaningful discussion about progressing towards Sam’s discharge from SECU.

Hearing 2

There wasn't another hearing in eight weeks because Sam was discharged from SECU and 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 that the support provided to Sam after his SECU discharge was limited to four home visits to administer depot.

Issues from the Tribunal's perspective were:

- 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 without 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 appears referrals and linkages to broader supports had not occurred and there were no plans for addressing 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.

10.6 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 hearings framework which guides its approach to all hearings.

Critically, and as noted elsewhere in this Guide, a solution-focused approach is not about miscasting the Tribunal as a source of solutions. 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?

10.6.1 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 to enable the most effective exploration of these issues in hearings with few surprises. One example where this has already occurred is the development of a tailored reporting template for hearings concerning SECU patients.

10.7 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. However, the Tribunal must be attuned to the reality of power imbalances and that an individual's ability to self-advocate may be limited.

10.8 Informed but not defined by the reality of available services

The mental health service system operates under significant capacity and resourcing constraints, and some of its critical intersections are with equally stretched sectors and 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.

The case of ‘Sophie’ from the Tribunal’s submission to the Royal Commission into the Victorian mental health system is a case in point.³⁶¹

‘Sophie’

Sophie was an inpatient who had been treated in a secure setting for nearly two years. She was receiving treatment for a psychotic illness and personality disorder. Sophie’s engagement and hard work with her multi-disciplinary team meant her recovery had progressed. She had made future goals and was regarded as having significant potential. Sophie and her treating team agreed the time was right for her to move on and ‘step down’. Accordingly, a referral was made to a less restrictive residential service in the area Sophie wanted to live so she was closer to family.

At a Tribunal hearing, Sophie’s treating team confirmed she was ready to transition but an impediment had arisen in relation to the service that had been identified as the appropriate ‘step down’ option. Accordingly, the Tribunal joined the relevant receiving service as a party to Sophie’s next hearing.

At the hearing, the proposed receiving service confirmed that it would not be accepting Sophie. Based on little direct contact with Sophie, and despite the treatment plan that had been being pursued for nearly two years, the position of the receiving service was that Sophie did not have a psychotic illness and so did not meet their treatment criteria.

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 these 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 intensively case-managed hearings to explore these issues in detail.

While the focus of these hearings is not to criticise or berate but to provide a forum for discussion and exploration of options for progress, there is also a place for accountability. The Tribunal can also play a role linking patients in a scenario such as outlined in the case study of Sophie with advocacy and legal services. In some instances, the Tribunal will also formally raise these cases with the Office of the Chief Psychiatrist.

10.9 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 the Tribunal should not be hesitant to provide space for this to occur. Research repeatedly confirms that 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 they feel they have 'won'.

Following on from this, it is important to emphasise that 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, it has 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.

³⁵⁸ This Chapter is adapted from the Monash Health – Mental Health Program Professorial Lecture delivered by Matthew Carroll, President of the Mental Health Tribunal, on 19 June 2017.

³⁵⁹ Section 68 sets out the domains of capacity, which include that the person understands the information they are given that is relevant to the decision. Section 96(3)(a) (in relation to adult patients) requires the Tribunal to have regard to the matters specified in section 93(2). These include the patient's views and preferences in relation to ECT and any beneficial treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes that the patient would like to achieve.

³⁶⁰ 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.

³⁶¹ Royal Commission submission, above n 42, p. 15.

Chapter 11 The place of risk in decision making under the Act

- It is not uncommon for treating teams to tell the Tribunal that while a person's mental health is currently stable and they are engaged with treatment, a Treatment Order is still needed to manage the risk of a person's possible future serious deterioration so they can act assertively if the need arises. The rationale for this seems to be that if a person receiving voluntary treatment begins to relapse and disengage from treatment, intervention will not be possible until a relapse fully plays out and the serious deterioration has become an actuality.
- This approach or argument fails to recognise the preventative focus of the Act which allows compulsory interventions to be initiated to prevent a crisis. The Act does not limit compulsory treatment to being a response to a crisis after it has occurred.
- The Chapter also explores the Tribunal's approach to deciding the duration of Orders, namely by focusing on the question: what is required at this time and warranted by the available evidence? This analysis is informed by a view that the principles of the Act, including allowing dignity of risk, are best promoted and realised not by making longer Orders that might be revoked at a future date, but by making Orders for the duration that appears to be required at present, and making a further Order in the future if needed.
- This Chapter explores some of the 'mixed messages' that decision makers are given about risk. On the one hand, they are encouraged to be less risk-averse, but on the other they are criticised if things go wrong after a less risk averse decision is made. A rigorous and comprehensive framework is proposed for evaluating decision making that promotes accountability, but does not ask anyone to predict the future.³⁶²

Risk is a necessary, unavoidable consideration in the decisions the Tribunal makes. However risk is not determinative. It is often a significant part of the picture but it cannot be the entire picture.

Where risk fits within decision making under the Act is a complex question. Decision making under the Act is somewhat of a hybrid beast that straddles several domains. Decisions are made in clinical settings but are not purely clinical. They must be lawful but are not legalistic in the traditional sense. Decisions can also be subject to high levels of scrutiny. While this is how it should be and it can be appropriate and constructive, it can also often be ill-informed and based on unreasonable criteria.

The Tribunal is acutely aware of the highly pressured nature of inpatient and community mental health services. Demand is high and capacity is finite, particularly in relation to inpatient care and support where available resources need to be 'rationed'. The Tribunal appreciates that in this environment, risk assessment and efforts to differentiate between the level of immediate risk of numerous individuals are inevitably key considerations. Commentary on these matters is beyond the scope of this Chapter. However, reflecting on the matters that come before the Tribunal and revisiting the provisions of the Act reinforces that for some individuals, the Act

encourages and accommodates an alternative approach to balancing risk, particularly when, how and for how long to respond to risk with the intervention of compulsory treatment.

11.1 The provisions of the Act

11.1.1 Dignity of risk

Despite the frequency that risk is referred to in discussions relating to the Tribunal, the Act only uses the term 'risk' a total of eight times – and never in relation to the potential consequences of not making a compulsory Treatment Order. In fact, arguably the most critical use of the term 'risk' in the Act is to challenge all of us to be less risk averse. Section 11(1)(d) of the Act sets down one of the mental health principles, frequently cited as the 'dignity of risk' principle:

Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.

The relative absence of the term risk from the provisions of the Act is something that is to be regarded as deliberate. It contrasts, for example, with proposed amendments to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMI Act)³⁶³ that would rewrite the legal framework applicable to leave arrangements for forensic patients and forensic residents. The proposed legislation employs the term 'risk' a total of 32 times, and in particular the formulation 'unacceptable risk of a person causing harm'. This means an amended CMI Act would be accurately described as establishing a legal framework very much focused on risk. However, the *Mental Health Act 2014* is different. This is not to suggest the Act is blind to or requires decision makers to ignore risk. Instead, it is a reminder that we potentially employ a reductive or limited consideration of risk if we forget to actively remind ourselves what the Act actually says.

The 'risk criterion'

Alongside the dignity of risk principle in the Act and its inherent challenge to be less risk averse, the other key provision is the second treatment criterion set down in section 5(b). This is often summarised or referred to as 'the risk criterion', when in reality it is much more nuanced. Section 5(b) states:

Because the person has mental illness, the person needs immediate treatment to prevent –

- (i) serious deterioration in the person's mental or physical health; or*
- (ii) serious harm to the person or another person.*

The first thing to note is that the 'risk criterion' does not actually use the term risk. This does not necessarily mean that as a form of abbreviation referring to risk is an entirely inappropriate way of distilling this criterion. It is quite accurate to say that section 5(b) is directed to the concern that, because of the symptoms of a person's illness, certain undesirable things (risks) might happen or eventuate in the absence of treatment. However, referring to section 5(b) as the 'risk criterion' does seem to contribute to a fundamental misunderstanding of the focus of section 5(b) – namely **prevention** – which, alongside the dignity of risk principle, can have significant

implications for when a Treatment Order is made, how it is used and how long it is made for.

The case studies in this Chapter demonstrate that in some cases:

- not making any Order can be the best response to risk in a given situation
- the authority of an Order doesn't always have to be used in full, and it can operate as a platform to negotiate and trial different, less restrictive responses to risk
- there is a potential downside to every decision that is made, and so when that decision is to make a Treatment Order, it should be for no longer than is warranted at the time.

11.1.2 When should a Treatment Order be made?

Consider two consumers – 'Jack' is a new patient and 'Mary' is an experienced consumer. Neither are individual case studies, nor are they especially novel. Each is an amalgam of many individuals and they represent two cohorts of patients that are frequently involved in Tribunal hearings.

'Jack' and 'Mary'³⁶⁴

'Jack' typifies a 'new patient'. He is in his early 20s and presents with a first episode psychosis. After some initial difficulties and a readmission shortly after his first discharge from hospital, Jack and his treating team are developing a positive rapport. Jack is still making sense of things but can at least partly identify with the notion of having symptoms of an illness, and particularly after his recent and rapid readmission to hospital, perceives a link between treatment and stability.

'Mary' is an 'experienced consumer'. She is in her late 40s and has a long history of bipolar affective disorder. Mary has lengthy periods of stability and while presently stable, has experienced severe relapses that in the past have had a devastating impact on her relationships, accommodation and employment.

It is not uncommon in Tribunal hearings involving patients like Jack or Mary for treating teams to acknowledge that things are going well but to argue that to manage the risk of future serious deterioration or serious harm, a compulsory Treatment Order is required to enable them to 'act assertively' if the need arises. When asked to elaborate on this, the rationale put forward is often that if a person is not on a Treatment Order, intervention will not be possible until a relapse fully plays out and the serious deterioration in Jack or Mary's mental health has become an actuality.

This is not what is required under section 5(b) of the Act, which more correctly should be referred to as the *prevention criterion* rather than the risk criterion. While every case requires specific consideration and ultimately an Order might be made, the Tribunal is increasingly questioning the rationale in support of Treatment Orders for Jack or Mary when the primary reason appears to be for an 'insurance policy' for the future.

Such an approach should not leave Jack or Mary vulnerable. This is because the prevention criterion doesn't just address risk – it also deliberately positions Treatment Orders as a preventative mechanism. In other words, the requirement of section 5(b) of the Act can be satisfied if there is evidence that demonstrates a serious deterioration in Jack or Mary's mental health is emerging as a real possibility and one that might be prevented with immediate treatment.

This is reinforced by the fact that when it comes to making an Assessment Order the test is lowered, in that any clinician who might be called on to consider making an Assessment Order for Jack or Mary only needs to be satisfied that they **appear** to need immediate treatment to prevent serious deterioration or serious harm (under section 29(b) of the Act).

It is also compatible with another of the mental health principles – that services should be provided with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life (section 11(1)(b) of the Act).

This approach brings the concepts of early warning signs or relapse patterns into the equation. These will be more easily identified in the case of someone like Mary who is known, than Jack who is less familiar. But in any case, it is not necessary to wait for a crisis to eventuate and rock-bottom to have been reached. The criteria for Assessment Orders, Temporary Treatment Orders and Treatment Orders contemplate and allow responding sooner to prevent the crisis occurring.

A further pitfall of reducing section 5(b) of the Act to a risk criterion and not fully appreciating its preventative focus, is that it arguably gives rise to a paradoxical approach to the interpretation and application of the dignity of risk principle. Dignity of risk has been described or defined as the principle of allowing an individual the dignity afforded by risk-taking, with subsequent enhancement of personal growth and quality of life.

Positive risk taking is associated with elements such as: improved autonomy, social interaction and health; the promotion of independence, self-determination and self-worth; and enabling people to construct lives that align with their values and personality. Conversely, over-protection or denying people the dignity of risk is associated with removing hope, diminishing the person and preventing people from achieving their potential.³⁶⁵

Dignity of risk is not benign indifference – there are boundaries. In the case of the Act, the boundary is that we are directed to respect a '*degree*' of risk. What is an appropriate or permissible degree of risk cannot be defined in the abstract and is something that needs to be assessed on a case-by-case basis. However, mistakenly thinking a crisis must have occurred before intervening in relation to a person not presently on an Order potentially leads to a very illogical approach to the dignity of risk.

It is relatively uncontroversial to propose that a person should be afforded the liberty to take on more risk, or make riskier decisions, when their level of appreciation or understanding of the relevant risks is higher, and/or other protective factors are present – which would include a high level of rapport or engagement with their treating team. Returning to Jack and Mary, applying for or making a Treatment Order in the brief scenarios outlined arguably amounts to denying them the dignity of risk when they are best positioned to take on that risk: Jack is collaborating with his

treating team; Mary is stable and has many years' experience of her illness to draw upon. If this isn't the time to afford dignity of risk, when is?

Furthermore, let's assume that a Treatment Order isn't made for Jack nor Mary, but at some point in the future they begin to disengage from treatment and their mental health begins to deteriorate. If the preventative focus of the Act is misunderstood or overlooked, and intervention is delayed until a point when Jack or Mary's deterioration becomes a full-blown relapse or crisis, we have seemingly afforded them the greatest dignity of risk at a time when they were far less likely to have been in a position to take it on – when they were becoming more isolated and/or acutely symptomatic.

One further potential consequence of this misinterpretation of the Act is that by overlooking the preventative aspect of the assessment and treatment criteria, we interpret and operationalise the Act as if there were two different sets of criteria, depending on whether they are being considered in relation to a person who is voluntary, or a person who is a patient. If a person is on an Order there is a very high bar in terms of how well they must be for an Order to be revoked. In contrast, for a person who is not on an Order the bar is inverted and they must be extraordinarily unwell for an Order to be made. This is not supported by the provisions of the Act, which set down the one set of criteria to be applied regardless of a person's legal status at a given point in time.

11.2 How a Treatment Order can be used

Another key principle of the Act is that voluntariness is to be preferred (section 11(1)(a)). This can be a challenging principle to adhere to in the case of an individual with a high and longstanding risk profile. It can be even more difficult to grapple with if the Act is understood in binary terms – compulsory versus voluntary treatment – when there is in fact an 'in-between' space. This is demonstrated in the case study of 'Andrew', which provides an example of a consumer and their treating team negotiating to use a Treatment Order creatively.

‘Andrew’

‘Andrew’ is a long-standing client of his treating service and has been treated on a compulsory Treatment Order for many years. For an extended period of time he has been making constant applications for his Treatment Order to be revoked. This has not occurred and so more recently Andrew has been saying he will ‘disappear’ to avoid treatment.

At Andrew’s most recent hearing the Tribunal was presented with an amended treatment plan, which was more a negotiated agreement or contract. The terms that Andrew, his treating psychiatrist and case manager had negotiated and put their names to included:

- a switch from depot to oral medication supported by intensive supervision for one month (shared between a pharmacist and the service)
- if supervised oral treatment went well, a switch to unsupervised treatment
- collaborative development of an Advance Statement
- weekly case management appointments alongside monthly psychiatrist appointments
- a commitment to consider revoking Andrew’s Community Treatment Order (CTO) if the agreement was adhered to
- a clear, transparent statement that if the agreement was not adhered to, the treating team may apply a further Treatment Order and might vary the CTO to an Inpatient Treatment Order (ITO) if Andrew’s mental state deteriorated.

Andrew and his treating team are to be commended for this strategy. A compulsory Order can often only do what its name implies – enable compulsory treatment. However, a compulsory Order can also be a platform for an arrangement that includes ceding some control to a patient. This involves trialling some or perhaps all the decisions the person would make if voluntary, working on their terms, but always being transparent about it being a trial and if needed, compulsory interventions will recommence immediately.

Other noteworthy aspects of this strategy included the following.

- It was potentially more likely to achieve the desired outcome. Andrew did appear to be someone capable of successfully evading treatment if he decided to do so. By negotiating an arrangement that tolerated some risk, the potential for a greater risk to be realised was arguably reduced.
- As a person who had been on a series of Orders for many years, Andrew understandably had a sense of grievance – an expectation he may never be considered in a different light, and that his future would always be pre-determined by his past. Even if things do not go well and a further Order is sought, having pursued this strategy meant any decisions that might need to be made about a further Order could be made based primarily on the present or very recent past, rather than assessments based on history that had not been challenged or re-tested.
- The strategy might work. It is often the case that when asked in the report or during hearings ‘what are the steps to less restrictive treatment?’ the answer provided centres around ‘insight’ and ‘adhering to treatment’. This is a slightly diplomatic way of saying a person can be voluntary if they agree with us and do as they’re directed. However, in this case, Andrew and his treating team worked to find a space they could co-habit. Andrew was unlikely to ever identify with a psychiatric diagnosis, and his treating team was never going to say: ‘let’s forget about all those serious incidents in the past’. To use the language of alternative dispute resolution, Andrew and his treating team moved from positional to interest-based engagement, and may have settled on an approach that is satisfactory and sustainable.

11.3 How long should a Treatment Order be made for?

A divergent approach to the consideration of risk between the Tribunal and clinicians informs a phenomenon that emerged from the time the Act commenced; the Tribunal making Orders with a shorter duration than the maximum duration permitted by the Act, and in some cases for less time than proposed by the treating team. This is an aspect of decision making the Tribunal is seeking to interrogate and understand in greater detail, starting with a review of determinations over an eight-week period in 2017.

Based on the analysis to date, the Tribunal identified that:

- In the eight weeks, 18 per cent of Treatment Orders made by the Tribunal were for less time than requested by the treating team.
- The two most frequent reasons given for this were because it aligned with the principles of the Act (a factor in 78% of matters) and the presentations of parties at the hearing (a factor in 73% of matters). The most commonly cited principles were dignity of risk, and the preference for voluntary treatment.³⁶⁶

Potentially what is happening here is the Tribunal is endeavouring to take and encourage a more symmetrical approach to the discussion and consideration of risk. Reflecting on hearings, an observer could sometimes leave with the impression there is only one aspect of risk that needs to be considered: the risk of not making a Treatment Order. However, there are potential downsides (or risks) associated with every decision made. The asymmetry of current discussions can manifest in various ways.

- It includes attributing Orders with an unrealistic level of impact or effectiveness, or not acknowledging that people can and do sometimes relapse even when they are engaging with treatment voluntarily or in accordance with an Order.
- It can be demonstrated by a very cursory discussion about side-effects or using language that might inadvertently seem to marginalise concerns about side-effects. The presence of symptoms is often reported as a fact, but side-effects are 'alleged'.
- Rarely is the down-side, or the risk associated with coercion acknowledged and discussed. Returning to the case studies of Jack and Mary above, an important part of the discussion should be that making a Treatment Order might decrease their level of motivation to engage with treatment if they understand or perceive the reason for the Order as simply being a lack of belief in their stated intentions about what they would do if they were a voluntary patient.

Broadly, the Tribunal's approach to determining the duration of an Order (including the place of risk in those deliberations) might be summarised as: once it has been demonstrated the criteria for a Treatment Order are satisfied, we need to ask 'what is required *at this time* and warranted by the available evidence'? The principles of the Act, including allowing dignity of risk, are best promoted and realised by making Orders for the duration that appears to be required at present, and making a further Order in the future if needed (not by making longer Orders that might be revoked in future).

The case examples of 'Greg' and 'Sarah' illustrate this.

'Greg' and 'Sarah'

'Greg' has a long history of bipolar affective disorder and experienced a severe relapse. At the time of his Tribunal hearing, Greg was an inpatient and his treating team were seeking a six-month ITO. Greg's symptoms were responding to treatment, he had a supportive family, and an established 'track record' of voluntary treatment when relapses had resolved. The Tribunal made a 12-week Order. Why make it for longer when Greg's history demonstrated he was highly likely to engage with treatment voluntarily in a much shorter period of time?

'Sarah' had a diagnosis of schizoaffective disorder with two recent hospital admissions. Sarah had returned home by the time of her hearing and the treating team were seeking a 12-month CTO. A complicating aspect of the hearing was that none of the representatives of the treating team knew Sarah and there wasn't a treatment plan. A further issue of concern was that Sarah had completed a residential drug rehabilitation program but had recently recommenced using substances. Sarah explained a reason for this was that despite making efforts to address her challenges, she felt little had changed in that she was still being treated as a patient. The Tribunal made a six-week CTO – there was insufficient evidence to support a longer Order – and in the circumstances of the hearing there was no opportunity to meaningfully explore the potential downside of a long Order.

11.4 How should decisions about risk be evaluated?

In any exploration of the place and role of risk in decision making, it is important to acknowledge the broader pressures that can bear down on any person working under the Act. These can be at the back or front of people's minds.

Whether you are a clinician considering and weighing up risk in the context of providing treatment and support to an individual, or a Tribunal member determining a person's status under the Act, the task is difficult. In some matters the weight of information or evidence overwhelmingly points to one conclusion, but more often there are equally valid considerations that pull us in opposing directions, and the end point is one on which reasonable minds can differ. However, scrutiny and criticism of decision making by various entities and the general community is often and unreasonably conducted through the lens of the 'retrospectoscope'.

We cannot predict the future, and this includes the future conduct and decision making of any person with a degree of self-agency. Individual decision makers lack this predictive ability, and so do assessment tools which can inform and contribute to sound decision making, but of course do not tell us that A+B will result in C. We know this, but each time we read a headline along the lines of 'How could this be **allowed** to happen?' we confront the reality that firstly, the wider community doesn't appear to understand this, and secondly, there is a reluctance to be transparent with the community and say not all risk can be eradicated. In other words, there are high levels of risk illiteracy.

Acknowledging this is not to abrogate responsibility. Dr Sally Wilkins, a former psychiatrist member of the Tribunal, has explored decision-making accountability in detail.³⁶⁷ As Dr Wilkins proposes, decision makers must be accountable for decisions, but that accountability should be for the quality of decision-making processes, and not for autonomous decisions and actions of individuals that occur after a decision has been made in accordance with a rigorous decision-making process. The case of 'Helen' is a strong example.

'Helen'³⁶⁸

'Helen' was in her late 20s and an inpatient in a secure setting. She had an extensive drug taking history dating back to her early teens and a long-standing diagnosis of a mental illness. Her most recent admission was triggered by increased drug use. At the time of her hearing, Helen's acute symptoms had resolved, she was adhering to treatment and she was also six months pregnant. Helen's treating team was seeking an ITO. This was an entirely reasonable proposal given the level of chaos and deprivation that had characterised Helen's living conditions before her admission.

Helen's legal representative and community advocate were both arguing for a CTO, and in support of this had developed a comprehensive support plan for Helen. Various family members were moving to Melbourne to live with Helen, enforce a zero-tolerance policy regarding drugs, and support her adherence to a CTO. Helen's background included extreme trauma, and it was explained that ongoing inpatient treatment could be particularly damaging.

The Tribunal made a CTO. Some months down the track in a subsequent hearing for Helen, the Tribunal found out what happened after it made the CTO. Helen did resume her drug use before having her baby, and the baby was immediately taken into protective care. What is to be taken from this – was the decision to make a CTO wrong?

The fact Helen's community support plan failed is not the test or standard by which the quality of this decision should be assessed. That approach would require predictive powers and also makes the erroneous assumption that continued detention of Helen would not have potential downsides equally undesirable and serious. So how should it be assessed? What are the questions that should be asked in a retrospective assessment of decision-making quality, and especially in any assessment of whether risk was properly considered? Dr Wilkins proposes the following list:

- did the decision maker turn their mind to the issue of risk, including the likelihood and consequences of different outcomes?
- was all the available information sought out?
- was the perspective or view of those with relevant expertise (including direct knowledge of the individual situation) sought out?
- were the pros and cons of alternative decisions identified and considered, including how they intersected with the individual's preferences, values and long-term goals?

- was the law applied correctly?

Using a comprehensive and nuanced list such as this to reflect upon and assess previous decisions is robust and rigorous. It can also add to future quality improvement as questions of this type, should they be answered in the negative, inherently identify a step or practice that can be integrated or approached better in future decision making.

Importantly, such an analysis adds far more to learning and improvement than does an assessment rooted in a culture of blame ('something bad happened following your decision – it follows it's your fault'). This is vital if decision makers (in clinical settings or the Tribunal) are to adhere to the Act's implicit and explicit challenge to be less risk averse.

³⁶² This Chapter is based on a paper delivered by the President of the Tribunal, Matthew Carroll, at the Monash Professorial Lecture Series on 16 June 2018.

³⁶³ See the Crimes (Mental Impairment and Unfitness to be Tried) Bill 2020.

³⁶⁴ Royal Commission submission, above n 42, p. 29.

³⁶⁵ This section draws on Woolford, M et al, 'Exploring the concept of dignity of risk', *Monash Forensic Medicine*, Monash University, accessed on 18 June 2019 at: www2.health.vic.gov.au/~media/Health/Files/Collections/Presentations/S/Striving-For-Care-Excellence/Exploring-the-concept-of-Dignity-of-Risk.

³⁶⁶ That research has now been completed and published as, 'The role of the Mental Health Tribunal in setting duration of compulsory treatment in Victoria', *Psychiatry, Psychology and Law*, published online: 16 June 2020.

³⁶⁷ Dr Sally Wilkins was a former acting Chief Psychiatrist, psychiatrist member of the Forensic Leave Panel and Mental Health Tribunal, and member of the Coronial Council of Victoria. This material is taken from Dr Wilkins' presentation, 'Clinical Decision-making and Risk Assessment - why we need to change the paradigm,' *COAT Victoria Conference*, May 2017.

³⁶⁸ Royal Commission submission, above n 42, p. 32.

Appendix – Recovery Oriented Language Guide

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Recovery
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Recovery Oriented Language Guide - Second Edition Revised

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Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes.¹

The Mental Health Coordinating Council (MHCC) developed the ***Recovery Oriented Language Guide*** in 2013 because language matters in all aspects of life. It continues to be particularly important in the context of mental health and recovery. It is vital that words are used that convey hope and optimism, and support and promote a culture that fosters recovery.²

People living with mental health conditions are amongst some of the most disadvantaged people in the Australian community, and many live with psychosocial difficulties exacerbated by historical and current trauma, poverty, poor physical health and stigma and discrimination which often feature as part of everyday experiences.³ The words that we use may effect a person's sense of self and lead to more disadvantage and social exclusion.

The mental health and human service sectors acknowledge MHCC's *Recovery Oriented Language Guide*⁴ (the *Guide*) as an extremely useful resource. We have developed this second edition primarily to align with trauma-informed care and practice language approaches, introduce age-related language use and promote the use of supported decision-making language.

Development of the Guide has been informed by a number of sources including: International and Australian literature on trauma-informed and recovery oriented practice; conversations with the mental health practitioners across service sectors; and, most importantly, through listening to the voices of people with lived experience of mental health conditions concerning their recovery journeys.

The Recovery Oriented Language Guide underpins and informs all the work MHCC undertakes in both the policy reform space and in its sector development activities.

You can access this resource from the website at www.mhcc.org.au/our-work/resources

Recovery perspectives throughout life

Since 'recovery' was originally defined from the perspectives of adult mental health consumers, MHCC has sought to identify whether these standpoints also apply to people at different developmental stages of life.

The literature suggests that whilst the recovery oriented approach applies to everyone, the language and ways of communicating that approach need to be relevant to particular age groups. MHCC has expanded this edition of the Recovery Oriented Language Guide to include some material concerning the perspectives of young and older people at different stages of their recovery journey. It provides an opportunity for reflection on diversity, which includes young people coming to terms with the new experience of mental health and older people possibly coming to terms with this identity and other associated trauma, grief and loss experiences.

Whatever a person's stage of life, mental health and human services should be familiar with language that reflects a recovery oriented approach to practice, and have an awareness and understanding of the prevalence and impact of trauma, which may have resulted in a range of psychosocial difficulties, and have awareness of the ways in which this may present.

Cultural diversity considerations should always guide a worker in their communications.

When a worker is unsure of what is appropriate, they should ask the person what they would like in terms of language interpretation, disability aids, environmental accommodation or supports.

Whatever a person's background, developmental age or impairment experienced, workers should adopt strength-based language to encourage choice and control and support self-directed decision-making.

Just ask a person what they think would assist them achieve their aims and objectives, what they need now and in the future and how they can be supported to communicate and achieve their aims.

Every day we make a countless number of decisions. They are an expression of who we are - our uniqueness, our relationships with others, our achievements and hopes for the future. Sharing power is a key element in promoting recovery.

- Access to supported decision-making can assist a person of any age develop a sense of control over their lives and their recovery. Through decision-making we exercise control over our lives, experience new things and learn about ourselves. Decision-making is so important that it is recognised as a human right
- Decision-making is a skill that can be developed and practised with support.
- Supported decision-making can assist a person to live with meaning, dignity and greater independence.

Appropriate language is a vital component in communicating a sense of self-determination, because feeling powerlessness can be overwhelming, especially when decisions seem to be or are in the hands of others.

Research has shown that communication is only 7 % verbal and 93 % non-verbal. The non-verbal component is made up of body language (55 %) and tone of voice (38 %)⁵ so when communicating with someone it is also important to consider:

Being mindful of the non-verbal aspects of communication, as well as boundaries maintained, appropriate eye contact and using body posture that is non-threatening nor disinterested.

Always try to accommodate a person's developmental age, hearing, cognitive or language difficulties, the time and space to think, question and express their point of view.

It is important to be authentic, transparent and sincere.

Use plain English language where possible. Using everyday language can help anyone better understand what is happening to them, their condition, care and treatment or circumstantial change.

Collaboration and openness are largely achieved through developing rapport, through connectedness, and a sense of feeling respected and heard.

Guidelines for Recovery Oriented Language⁶

General Principles

The language we use:

- Represents the meanings we have constructed from experience
- Prompts attitudes, expectations and actions
- Should always reflect 'unconditional positive regard'⁷ for people.

We may be unaware of how the words we use reflect our attitudes and the impact they have upon those around us.

The words we choose reflect our attitudes - that we do (or do not) truly value people, believe in and genuinely respect them.

None of us should be defined by the mental health conditions or psychosocial difficulties that we experience, or by any single aspect of who we are; we should be respected as individuals first and foremost.

Our language needs to be:

- Respectful
- Non-judgemental
- Clear and understandable
- Free of jargon, confusing data, and speculative comment
- Consistent with our body language
- Sincere in carrying a sense of commitment, hope and presenting the potential for opportunity
- Strengths-based

We need to give thought to:

- How the language we use, is read and heard by the person to which we are communicating, and how it may positively or negatively contribute to their health and wellbeing
- What meanings we present to people to live by

Our language conveys our thoughts, feelings, facts and information, but beyond that, we need to be reflective in our practice and ask ourselves questions like:

- *What else am I saying?*
- *How will someone else read or hear this?*
- *Do I give a sense of commitment, hope and present opportunity or a sense of pessimism?*
- *Do I convey an awareness and expectation of recovery?*

The approach to language when talking to people needs to take into consideration where they are in their recovery journey. This may fluctuate in relation to their physical and mental health, and social and emotional wellbeing.

Some general guidelines for language and communications⁸

DO

DO put people first:

DO say “person with mental health condition”

DO say “a person who has been diagnosed with...”

DO emphasise abilities

*Do focus on what is strong
i.e., the person’s strengths, skills & passions*

DO use language that conveys hope and optimism that supports, and promotes a culture of recovery

DO enquire as to how the person would like to be addressed

DO use language that is comfortable for you and reflects your genuine, true self

DO clarify that people understand the information they have been given

Make sure that whatever a person’s age, cultural background and cognitive skills that they have understood what has been said

DON'T

DON'T label people:

DON'T say “he is mentally ill”, “she is mentally ill”

DON'T define the person by their struggle or distress

DON'T equate identity with a person’s diagnosis

Very often there is no need to mention a diagnosis at all. It is sometimes helpful to use the term “a person diagnosed with”, because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.

DON'T emphasise limitations.

Don’t focus on what is (in your mind) wrong with the person

DON'T use condescending, patronising, tokenistic, intimidating or discriminating language

DON'T make assumptions based on external appearances or communication difficulties

DON'T sensationalise a mental illness
This means not using terms such as “afflicted with,” “suffers from” or “is a victim of”

DON'T portray successful persons with mental health conditions as superhuman. *This carries the assumption that it is rare for people with a mental health condition to achieve great things*

DON'T presume that a person wants to be called by a particular term (e.g., consumer or client) and check whether the wish to be addressed by their family or first name (e.g., Ms Smith or Kylie) or another name which they identify

DON'T use jargon, or unfamiliar language.

DON'T use specialist or medical language unless you accompany it with plain English explanations

| DO | DON'T |
|--|---|
| DO use language that conveys optimism and positivity | DON'T use negative or judgemental language |
| DO ask <i>“what is important to you?”</i> | DON'T refer negatively to aspirations identified in the past that a person did not follow up |
| DO ask <i>“what are you looking forward to doing?”</i> | |
| DO ask <i>“what do you think might be steps forward”</i> | DON'T use the concept of goals with young people or older people unless it feels appropriate. Rather talk about aspirations, dreams and hopes |
| DO ask whether the person feels they have been consulted and listened to about their care, treatment or support plans | DON'T argue with a person's perception of events |
| DO validate a person's experiences | DON'T minimise a person's experience in the urgency of managing symptoms |
| DO ask whether the person has been given the opportunity to ask questions, and check that they have the information they need | DON'T argue that information was already provided or known |
| DO check that an older person has heard and understood what has been said clearly - when you know or sense they may have hearing and/or cognitive difficulties | DON'T assume that having said something, that it is understood |
| DO allow people the time to find the words and express what they need to say | DON'T jump in and speak for someone |
| DO ask people if they feel ready to make their own decisions or would like to be supported, and in what way | DON'T tell someone that certain information is irrelevant |
| DO ask what has been helpful and unhelpful in the past | DON'T harp on failures of the past |
| DO involve people in the development of treatment, care and support planning | DON'T assume that you know what is best for a person |
| DO involve others providing care coordination across services | DON'T devise treatment, care or a support plan without consultation with the person you are working with |
| DO be mindful of the importance of individual identity to all people, but be particularly sensitive to peoples' fears of being considered to lack decision-making capacity | DON'T make assumptions about people based on their diagnosis |
| DO be mindful of older people's fear of losing their sense of identity or a young person being considered mature enough to make decisions | DON'T make assumptions about age or disability. Remember older people have a lifetime of experience, and many young people have roles of responsibility despite their age |

Out-dated and worn-out words⁹

Language of Acceptance, Hope, Respect & Uniqueness

Worn-out words

- | | |
|--|--|
| <ul style="list-style-type: none"> ■ Kylie has a mental health condition or a disability | <ul style="list-style-type: none"> ■ Kylie is not normal |
| <ul style="list-style-type: none"> ■ Sam lives with a mental health condition ■ Sam is a person with lived experience of ■ Sam has been told he has schizophrenia ■ Sam has been diagnosed with ■ Sam has experienced anorexia ■ Sam is a person with lived experience of trauma ■ Sam is a person who experiences mental health and co-existing difficulties with substance use | <ul style="list-style-type: none"> ■ Sam is mentally ill ■ Sam is schizophrenic ■ Sam is a bipolar ■ Sam is an anorexic ■ Sam has PTSD ■ Sam is a PD ■ Sam is a borderline ■ Sam has drug problems |
| <ul style="list-style-type: none"> ■ Kylie is having a rough time ■ Kylie is having difficulty with her recommended medication ■ Kylie's medication is not helping her ■ Kylie is experiencing unwanted effects of her medication ■ Kylie disagrees with her diagnosis ■ Kylie is experiencing ... | <ul style="list-style-type: none"> ■ Kylie is decompensating ■ Kylie is treatment resistant ■ Kylie is uncooperative ■ Kylie doesn't accept she is mentally ill ■ Kylie has no insight |
| <ul style="list-style-type: none"> ■ Sam is trying really hard to self-advocate and get his needs met ■ Sam may need to work on more effective ways of getting his needs met | <ul style="list-style-type: none"> ■ Sam is manipulative, irritable ■ Sam is demanding and unreasonable ■ Sam has challenging or complex behaviours ■ Sam is dependent |
| <ul style="list-style-type: none"> ■ Kylie is choosing not to... ■ Kylie would rather look for other options | <ul style="list-style-type: none"> ■ Kylie is non-compliant ■ Kylie has a history of non-compliance |
| <ul style="list-style-type: none"> ■ Sam is pleased or satisfied with the plan we've developed together ■ Sam and the team have developed a good rapport ■ Sam is able to seek help and recognises when things are not going so well ■ Sam is working hard towards achieving his goals ■ Sam is taking each day at a time | <ul style="list-style-type: none"> ■ Sam is compliant or manageable ■ Sam has partial insight ■ Sam is cooperating ■ Sam has acquired insight ■ Sam is learning to manage his illness ■ Sam is unmotivated |

Language of Acceptance, Hope, Respect & Uniqueness

Worn-out words

- Kylie chooses not to...
- Kylie is concerned about the health implications of her treatment plan
- Kylie prefers not to...
- Kylie is very independent
- Kylie seems unsure about...
- Kylie might benefit from some help at home

- Kylie has no insight
- Kylie is treatment resistant
- Kylie refuses support
- Kylie won't engage with services
- Kylie needs support with her ADLs
- Kylie is low functioning

- Sam is really good at...

- Sam is high functioning

- Kylie has a tough time taking care of herself
- Kylie has a tough time learning new things
- Kylie is still considering her options
- Kylie is still working out what she needs

- Kylie is low functioning

- Sam tends to (describe actions, e.g., hit people) when he is upset
- Sam sometimes kicks people when he is hearing voices
- Sam is finding it difficult to socialise
- Sam likes his own company

- Sam is dangerous; abusive; angry, aggressive
- Sam demonstrates challenging, high risk behaviour/s
- Sam is high risk
- Sam is anti-social
- Sam is isolative
- Sam doesn't want to socialise

- Kylie is experiencing both mental health and substance use problems
- Kylie tends to use non-prescribed substances to help manage distress/cope with life

- Kylie is dually diagnosed
- Kylie has comorbidities or is comorbid
- Kylie is MICA/MISA (mentally ill chemically abusing, mentally ill substance abusing)
- Kylie is an addict

- Sam doesn't seem ready to go back to work
- Sam is not in an environment that motivates him
- Sam is working on finding his motivation
- Sam has not yet found anything that sparks his interests

- Sam is unmotivated
- Sam is not engaged or does not want to be engaged
- Sam isolates
- Sam rejects help

- Kylie has a lot of energy right now
- Kylie hasn't slept in three days
- Sam is experiencing a lot of fear
- Sam is worried that his neighbours want to hurt him
- Sam often disagrees and gets angry with his family, friends etc
- Kylie has been working towards recovery for a long time
- Kylie has experienced serious depression for many years
- So far, Kylie has not accessed support that has been helpful to her

- Kylie is manic
- Kylie is hyper
- Sam is paranoid
- Sam is delusional
- Sam is aggressive
- Kylie has a chronic mental illness
- Kylie is severely mentally ill
- Kylie will never recover - she rejects help

- Sam and I aren't quite on the same page
- It is sometimes challenging for me to work with Sam
- Sam has not had good experience with services in the past
- Sam is a young person who has recently been given a diagnosis and is having difficulty to come to terms with this news

- Sam is very difficult
- Sam has challenging behaviour
- Sam won't engage with services
- Sam doesn't accept what he has been told by the treating team

If worn out words are used to describe people's attempts to reclaim some shred of power while receiving services in a system that may try to control them, then important opportunities to support a person's recovery will be lost.

A person trying to get their needs met - may have a perception or opinion different from, or not shared by, others - and their actions may not be effectively bringing them to the results they want.

- Manipulative
- Grandiose
- In denial
- Passive aggressive
- Self-defeating
- Oppositional
- Personality disordered

- Charles is an older person who displays frustration at times
- Charles is someone used to being independent who is finding it difficult accepting support
- Charles may need some support to help him make decisions
- Charles may need support in some areas of his life
- We need to find out what we can do to support Charles that best suits him

- Charles is a challenging, difficult, grumpy man
- easily angered, irrational and short tempered
- Charles rejects help and advice
- Charles isn't capable of deciding for himself what's best
- Charles has complex needs
- Charles has poor ADLS
- Charles is uncooperative

Key Terms

A Consumer is a person with lived experience of a mental health condition who is accessing or has previously accessed a mental health service.¹⁰ Within a child and youth mental health context, both the parents and the child or young person may sometimes also be described as consumers.

Capacity refers to a person's ability to make his/her own decisions. These may be small decisions, such as what to do each day, or bigger decisions such as where to live or whether to have an operation. A person may lack capacity in some areas, but still be able to make other decisions.

Cognitive functioning refers to the underlying cognitive processes that allow for effective information processing that assist decision-making, planning and completing actions.

Complex need is commonly used to refer to individuals who present with an inter-related mix of diverse mental health and physical health issues, developmental and psychosocial problems.

Dignity of Risk refers to the individual's right to make informed choices in relation to a variety of life experiences and take advantage of opportunities for learning, developing competencies and independence and, in doing so, takes a calculated risk.

Diversity is inclusive of but not limited to the diversity among people with respect to culture, religion, spirituality, disability, power, status, gender and sexual identity and socioeconomic status.¹¹

Peer Work is a fast growing occupational group in the mental health workforce. Peer services are a core component of a genuinely recovery based service. Peer work, peer workers and peer workforce includes all workers in mainstream or alternative mental health services or initiatives who are employed to openly identify and use their lived experience of mental illness and recovery as part of their work. Peer support workers provide support for personal and social recovery to other people with mental health conditions, including in acute mental health settings housing, supported employment, community-based support and so on.¹²

Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities. It is characteristically used to describe many negative outcomes for a person living with a mental health condition attempting to interact with a social environment that presents barriers to their equality with others. Psychosocial disability may also describe the experience of people regarding participation restrictions related to their mental health conditions as the loss of or reduced abilities to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Recovery is defined as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.¹³

Somatisation is a tendency to experience and communicate psychological distress in the form of somatic symptoms and behavioural features. More commonly expressed, it is the generation of physical symptoms of a psychiatric condition such as anxiety.

Supported decision-making is an approach designed to support people make significant decisions, exercise their legal capacity, make day-to-day choices and draw upon their strengths and support networks.

Trauma-informed is the re-conceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised acknowledging the prevalence of trauma throughout society. 'Trauma-informed' services are aware of and sensitive to the dynamics of trauma as distinct from directly treating trauma per se.

Talking to people at both ends of the age spectrum

Young People

Just like with people from other groups or diverse cultures, when communicating with a young or older person using language that they are comfortable with is important. Be guided by their style of speech.

Young people are no different to adults in expressing the importance of collaboration and openness as worker attributes. What is particularly meaningful is displaying a genuine interest in people and their lives. Asking “how’s everything going?” can be a good way of opening the door to a conversation about anything that they may need or like to talk about. Young people characteristically relate more to concepts of health and wellbeing rather than illness and recovery.

Use language that is real and familiar rather than imitate young people.

The idea of being asked to formulate recovery goals, particularly for young people can lead them to feel judged, especially when they are unable to list concrete objectives.

Instilling hope is vital to everyone, but some young people feel overwhelmed thinking of the future. Talk instead about hopes and dreams that may have for themselves.

Workers should not feel uncomfortable or needing to use language that they wouldn't normally use. However it is important to understand that swearing and 'bad language' is a prominent feature in the vocabulary of many young people - both when things are going well and when things are challenging.

A young person may say “I feel crap” or “this is shit”. Enabling conversation that is accepting of this language is important in establishing rapport with a young person. Some of the expressions used by young people may offend others from different age groups and cultures, nevertheless, it important to be accepting of contemporary vernacular.

An alternative approach is to refer to 'steps forward' rather than 'goals'. For example, "what do you think may be some useful steps forward?" or "what are you looking forward to doing (e.g. when you are discharged from hospital, go home etc.)?" Young people are often figuring out who they are and what they want of life and don't want to be cornered.

Young people are increasingly comfortable using technology-based communications to discuss their emotions and experiences.¹⁴ It would appear that the absence of social cues such as facial expressions and gestures provides young people with an opportunity to disclose serious or sensitive information in what they perceive as a less-judgmental environment (where they can meet and converse with like-minded people).¹⁵ Health practitioners have noted that meeting young people in a space where they are comfortable can help build rapport and improve communication, even when online.¹⁶ Having discarded the formalities of meeting face-to-face, online communication can offer a vehicle for frank and sincere discussion about a person’s mental health difficulties.

The NSW Child and Adolescent Mental Health Services Competency Framework¹⁷ identifies the importance of mental health workers being culturally sensitive to adolescents when working with them; for example, appropriate non-verbal communication, eye contact and body posture.

Older persons

Using a recovery oriented approach sets out to enable a person living with a mental health condition to create and live a meaningful and contributing life in their community of choice.¹⁸

Many older people have a clear sense of who they are and how they define themselves, and can build on a lifetime's experience and resilience which can buffer the impact of any illness or circumstance.

Working with older people often includes:

Supporting a person to maintain a sense of enduring self-identity. Older people living with mental health conditions have described this as 'continuing to be me'.¹⁹ It is important to express a genuine interest in knowing who they are.

Understanding that for some older people's mental health conditions may have become so entrenched that their sense of who they are is compromised by illness and its impacts. This may result in them appearing helpless and hopeless. The language we use should reflect the fact that there are other perspectives without minimising what they are actually feeling.

Awareness that older people tend to conceptualise recovery rather differently to young people and adults more generally. Their aim may be simply to maintain a sense of who they are despite the disabilities they experience, and be valued and respected to know what they want and need.

Considering that a person may feel patronised and cornered when asked about goals for recovery. Older people may prefer to have their recovery journey expressed in a way which focuses on what will give them the best life they can live in the circumstances.

There is evidence suggesting that older people's dignity and autonomy is being undermined in health care settings and that a sizable cross section of healthcare professionals hold stereotypical, negative attitudes towards older people.²⁰ Diminishing mental health among older people is often not identified by relatives, health care professionals and older people themselves who may attribute symptoms of to the effects of ageing or to physical and environmental changes.

Often service providers make assumptions about older people, and what is appropriate communication. Important to language in this context is communicating respect and supporting choice and autonomy whatever difficulties a person may be having. Importantly, assuming capacity as a first principle.²¹

Three components of recovery appear to be distinct to older people: the significance of an established and enduring sense of identity; coping strategies which provide continuity and compensation and therefore reinforce identity, and the impact of coexisting physical illness.

It is vital that when communicating with an older person that they are supported to have their voice heard and their choices understood. Older people should be reassured that their autonomy and ability to self-determine life choices will not be undermined unnecessarily, especially when other disabilities may be involved.

Avoid asking others, even those close to them about what they want, unless a person clearly wants someone else to speak on their behalf, or are unable to communicate their preferences.

A trauma-informed recovery-oriented approach

Recovery orientation has been adopted as an overarching philosophy to guide mental health practice and is embedded into policy and standards nationally.²² An understanding of trauma is integral to a recovery-oriented approach. In fact developing and implementing trauma-informed systems of care is one of the first steps towards becoming recovery oriented. Critical to this objective is to use language that reduces the possibilities for re-traumatisation and harm within service systems and practice. A trauma-informed recovery-oriented approach is person centred and involves sensitivity to individuals' particular needs, preferences, safety, vulnerabilities and wellbeing, recognises lived experience and empowers people with lived experience to genuinely participate in decision-making.

Overarching guidelines

- Speak or write about a person with a mental health condition, psychosocial disability, cognitive impairment, problem and/or difficulty; not about a disorder, diagnosis, symptom/s and/or case or bed or a derisory term such as 'frequent flyer' or 'blocked bed'.
- Always include a description of a person's strengths and resourcefulness alongside the difficulties they experience.
- Where applicable, explicitly own words and concepts such as diagnosis or assessment as from a medical/service provider opinion or perspective rather than as a pronouncement of universal truth.
- Do not make assumptions and describe achievements, possessions or connections as merely grandiose delusions.
- Do not assume that disclosures of abuse are necessarily imaginary or represent part of the psychosis a person may be experiencing.
- Do not assume that risks presented in files and notes that relate to the distant or very distant past have current relevance.
- Record people's progress and their efforts towards their own recovery, the steps forward that they have made, using the person's own words and meaning.
- Where there are different views between the person writing a letter or report and the person it is important to:
 - include recognition of that awareness
 - describe their viewpoint in their own words, and
 - describe how their viewpoint contrasts with the author's

For example, "*whereas I think ... I'm aware that Sam has a very different point of view and considers or stated that ...*"

 - Note directions for negotiating these differences
- Express 'shortfalls' as work or progress still to be achieved.
- Record the person's own hopes or ambitions as well as those held by the support or treating team and what needs to happen for such hopes to be realised.
- Seek to express issues of risk (safety appraisal) in terms of planning for recovery, safety and success; including for people who may be required to comply with involuntary treatment.
- Seek to ensure that issues of compromised safety include risk of re-traumatisation as a consequence of a range of involuntary treatment, including detention in a hospital environment.
- When actions are suggested that the person disagrees with, give a clear reason why these are considered necessary in terms of supporting someone's recovery, and acknowledge their alternate view.
- Ensure demonstration of respect with reference to people's concerns about the physical and psychological impacts of medication/s that they are expected to accept, and that discussions appropriately factor in the competing risks.
 - When there is opportunity, such as in regards to Mental Health Review Tribunal determinations, always offer a copy to the person following the hearing decision.
- In respect to reports to be presented to a Tribunal, always offer to discuss the draft prior to a hearing unless there is good reason, in which case:
 - offer to review and respond to their views on what you have written
 - where there are significantly different viewpoints, consider how these can be included either by amending what you have written if it is acceptable to you or otherwise include a description of the person's alternate viewpoint in the file

- Be aware that letters and reports are constructions rather than objective descriptions:
 - where possible, write reports with the person they are about, while at the same time preserving the integrity and authenticity of your own viewpoint
 - Where not possible, write them knowing that the person may read them
- Where there is a practice of offering people copies of letters written about a person, consider if the letter could instead be written directly to the person it is about - as a record of the conversation and a reminder of decisions - and copied to the other relevant parties (e.g., peer workers, support workers, general practitioners).
- Set up recovery-oriented language prompts in organisational documents and data templates, and include in continuous improvement audit processes.
- Ensure that in talking to anyone, that environmental safety has been established before discussing anything that may represent a trauma trigger for a person you are supporting.

Cultural Diversity

People from different cultures may express their distress in physical or somatic symptoms, or in descriptive terms unusual to you. It is important that workers pay attention to the person's description of their lived experience.

Living with a mental health condition may be considered a weakness in some cultures, and some people may find a diagnosis shaming or guilt provoking, whilst others may consider it a relief to put a name to their difficulties. Try and find out how a person's culture affects the way they perceive their condition and use language that most appropriately relates to their experience.

Talking About Suicide²³

One impetus to change the language of suicide began in the bereavement community. In addition to the insensitive language often used to describe suicide, and the silence and denial - the absence of suicide language and conversation is a major contributor to the stigma people face in the community.²⁴

Suicide often leaves the bereaved with especially acute feelings of self-recrimination. Those who are left behind may feel the full burden of suicide's stigma, and can feel abandoned and ashamed. Added to this injury is the mention of suicide in euphemistic language that goes to great lengths to neutralise the real meaning that exists concerning death as a consequence of suicide and the loss attached to it. Because this silence can be debilitating, the need for language that addresses the act of suicide in a direct but respectful way was identified and has, in recent years, gathered momentum.²⁵

Suicide is no longer a crime, and so we should stop saying that people commit suicide. We now live in a world where we seek to understand people who experience suicidal thoughts, behaviours and attempts, and then to treat them with compassion rather than condemn them.²⁶ Part of this is to use appropriate, non-stigmatising language when referring to suicide.

Often people seek attention from others for comfort and reassurance when they are distressed. In the context of a suicide attempt or suicidal ideation people are often described as 'attention seeking'. This is unhelpful language suggesting that a person is repeatedly displaying negative behaviours to gain attention. It is important to acknowledge the sequence of events leading to the situation arising and then state the actual behaviour of concern.

Appropriate Words

- Died by suicide
- Took his or her life
- Ended his or her life
- Non-fatal attempt at suicide
- Attempt to end his or her own life

Worn-out words

- Committed suicide
- Successful suicide
- Completed suicide
- Failed attempt at suicide
- Unsuccessful suicide

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