Mental Health Tribunal

Mental Health Tribunal submission in response to the *Mental Health and Wellbeing Act: update and engagement paper*

July 2021

VICTORIA State Government

Mental Health Tribunal submission in response to the *Mental Health and Wellbeing Act: update and engagement paper*

Mental Health Tribunal

Level 30, 570 Bourke Street Melbourne Victoria 3000
Phone: (03) 9032 3200 Vic Toll Free: 1800 242 703 Fax: (03) 9032 3223
Email Mental Health Tribunal <mht@mht.vic.gov.au>
Mental Health Tribunal <http://www.mht.vic.gov.au/>

To receive this publication in an accessible format phone the Mental Health Tribunal on 03 9032 3200, using the Translating and Interpreting Service by phoning 131 450 if required, or email the Mental Health Tribunal <mht@mht.vic.gov.au>.

Available at Mental Health Tribunal <http://www.mht.vic.gov.au/>

Contents

Executive Summary

Developing the new Mental Health and Wellbeing Act is in equal measure an exercise in imagination as well as legislative drafting. It is one of the first steps in realising the vision of the Royal Commission into Victoria's Mental Health System (Royal Commission), but it is being developed, and will initially operate within a current system that bears little resemblance to that vision. This is not an impediment to reform, but it does mean whatever its provisions, our understanding of the Mental Health and Wellbeing Act will evolve rapidly over time.

This should be energising and a cause for optimism, particularly as this reform of mental health legislation is accompanied by an already tangible commitment to resource the mental health sector to become the holistic mental health and wellbeing system designed by the Royal Commission. The relatively short life of the current Mental Health Act has proven law reform alone cannot embed cultural change when there is insufficient capacity to engage with the question of what that cultural change truly means and requires. In this period of unprecedented reform we really can translate the principles and aspirations captured in the law, and ensure they are reflected in the day-to-day experience of those receiving mental health and wellbeing treatment and support.

The Mental Health Tribunal (Tribunal) has not commented on all the proposed reforms outlined in the *Mental Health and Wellbeing Act: update and engagement paper* (engagement paper). We have focused on those where our current functions position us to offer a perspective based on experience and direct observation.

a) Objectives and principles of the new Act

Regarding the proposed objectives and principles, we believe they should capture more explicitly the key components of the integrated treatment, care and supports recommended by the Royal Commission, and also the strategies to support the mental health workforce. We have suggested adding to the principle regarding compulsory treatment and restrictive practices being a last resort. We have also proposed an option for increasing the Tribunal's own accountability for its compliance with the principles, in a way that is compatible with our quasi-judicial decision making functions.

b) Non-legal advocacy, supported decision making and information sharing

The Tribunal hopes that the support provided to consumers by non-legal advocates will extend to include involvement in Tribunal hearings. We have recommended that the increased prominence given to supported decision making include a particular focus on instances when ECT is administered on a compulsory basis under an Order made by the Tribunal. As an entity that accesses information directly, and observes the frustrations that can be encountered by others trying to do so, we think the focus on information sharing is very positive and have offered further suggestions to promote meaningful access and address some complexities, including in situations involving family violence.

c) Compulsory assessment and treatment

The Tribunal has concerns regarding some of the proposed changes to the criteria for the making of compulsory Treatment Orders, in particular the focus on *distress* and

imminence. We have not proposed specific, alternate criteria, but believe the most effective criteria will be crafted by reflecting on the type of dialogue and deliberation the criteria should foster, whether that be in clinical spaces or Tribunal hearings. To that end we have put forward options for consideration. Concerning the making of Treatment Orders –

- The criteria in the Mental Health and Wellbeing Act should set down all relevant considerations, and if they are met a Treatment Order should then be made. The Tribunal does not support the making of a Treatment Order being discretionary even where the criteria apply.

- Whatever maximum duration for Treatment Orders is set down in the Mental Health and Wellbeing Act we believe the Tribunal should be obliged to consider the proposed plan for the provision of treatment and supports when making a decision on duration.

- The Tribunal is very supportive of the proposal for a system of Tribunal conferences; however, we do not think it should be on the scale proposed in the engagement paper. The Tribunal would prefer a narrower approach to the use of conferences so that in effect, conferences could be trialled and refined before a decision is made about their broader relevance and use.

The Tribunal firmly believes the Mental Health and Wellbeing Act should commence the process of cultural change in relation to dignity of risk and risk management. It should seek to foster an environment in which a high bar is set in relation to the rigour of decision making – that is risk needs to be thoroughly considered and all relevant evidence sought out and competing considerations weighed up – but at the same time dismantle the impossible bar or expectation of predicting outcomes and controlling future events.

d) Housekeeping amendment

If the current scheme of Treatment Orders and hearings is replicated in the Mental Health and Wellbeing Act, long-standing problems with the provisions governing the variation of Treatment Orders should be rectified.

The objectives and principles of the new Act

1. The proposed elevation of the principles in the future Mental Health and Wellbeing Act, in particular that relevant entities *make all reasonable efforts to comply*, rather than simply *have regard* to the principles, is very positive. Increased oversight and accountability, including an obligation for annual reports to include information about how the principles are being embedded and the objectives advanced is also welcome.

2. The Mental Health Tribunal's (Tribunal) comments regarding the proposed objectives and principles concern:

    - reflecting the breadth of treatments and supports recommended by the Royal Commission into Victoria's Mental Health System (Royal Commission)
    - recognition of the support that needs to be provided to services to enliven the objectives and principles
    - the intersection between guidelines issued by the Mental Health and Wellbeing Commission (MHW Commission) and the decision-making functions of the Tribunal
    - the intersection between the complaint jurisdiction of the MHW Commission and the Tribunal
    - proposed principles 2 and 3.

Treatments and supports

3. Throughout its final report the Royal Commission repeatedly emphasised that a core function of the mental health and wellbeing system would be to deliver integrated treatment, care and support comprising:

    - treatments and therapies
    - wellbeing supports
    - education, peer-support and self-help
    - care planning and co-ordination. [1]

4. The proposed objectives and principles refer to *a* 'diverse range of comprehensive, compassionate, safe and high quality mental health and wellbeing services'[2], and a 'diverse mix of treatment, care and support'.[3] While there is obviously a limit to the level of detail that can be reflected in statutory objectives and principles, consideration should be given to further

[1] Royal Commission into Victoria's Mental Health System, 2021, *Final Report,* State of Victoria, Melbourne. Volume 1, Chapter 5, figure 5.5, 232.

[2] Department of Health, 2021, *Mental Health and Wellbeing Act: update and engagement paper,* State Government of Victoria, Melbourne, 9.

[3] Ibid, 8.

capturing the diverse range of supports that are to be part of the future mental health and wellbeing system. The Royal Commission's formulation is notable for the breadth of what is to be provided (including self-help, peer support, psychological and medical supports), its emphasis on planning and the recognition of the complementarity and interconnection of treatments and supports. The Royal Commission also emphasised treatment in the community close to where a person lives. It is important to reflect these defining characteristics of the future mental health and wellbeing system in the objectives and/or principles.

Supporting mental health and wellbeing services to enliven the objectives and principles

5. Many of the reforms to be implemented in the coming years have a vital focus on equipping service providers to deliver the mental health and wellbeing system envisaged by the Royal Commission. This is not just about funding. It includes a strategic and comprehensive approach to: workforce planning; ongoing training, development and workforce wellbeing; incubating innovation and collaboration; and fostering best practice. This warrants explicit recognition in the objectives of the Mental Health and Wellbeing Act.

6. Below, at paras 36-39, the Tribunal addresses the question of what role the Mental Health and Wellbeing Act can play in promoting cultural change concerning dignity of risk. The proposed principles refer to respecting decisions that involve a degree of risk[4], which is very similar to the approach in the current *Mental Health Act 2014*[5]. For the reasons outlined at paras 36-39, consideration should be given to going further. One possibility would be for the objectives or principles to acknowledge the need to support service providers and decision makers to adopt practices or make decisions that are less risk averse.

MHW Commission guidelines and complaints and the functions of the Tribunal

7. Empowering the MHW Commission to issue guidelines regarding the interpretation and application of the principles and confirming a failure to make all reasonable efforts to comply with the principles as an explicit ground of complaint are both positive. The legal principles that ensure guidelines and similar resources can inform but not limit or interfere with the type of quasi-judicial decision making performed by the Tribunal are well established. However, to ensure clarity across a very broad group of stakeholders, consideration should be given to excluding the Tribunal from the definition of a decision maker.

8. This exclusion need not be absolute, an approach informed by section 4(1)(j) of the *Charter of Human Rights and Responsibilities Act 2006* (Charter) could be adopted. This would mean

[4] Ibid, 10. Proposed principle 4 is: 'involve people receiving mental health and wellbeing services in all decisions about their assessment, treatment and recovery and ensure they are supported to make, or participate in, those decisions, and respect their views and preferences, including when those decisions involve a degree of risk.'

[5] *Mental Health Act 2014*, section 11(1)(d): '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.'

that in relation to its administrative operations, a concern that the Tribunal had not made all reasonable efforts to comply with the principles could be the subject of a complaint to the MHW Commission. If such an approach is to be adopted the Tribunal would appreciate having an opportunity to provide further input.

Proposed principles 2 and 3

9. References to restrictions on rights are made in proposed principle 2 and 3. The Tribunal suggests a slightly different approach:

> *2. provide access to a diverse mix of treatment, care and support, taking into account the needs and preferences of people living with mental illness or psychological distress and with the ~~least possible restriction of rights with the~~ aim of promoting recovery and full participation in community life*
>
> *3. ensure compulsory treatment and restrictive practices are only used as a last resort, and if they are used, it is with the least possible restriction of rights.*

10. Expressing principle 2 without reference to restricting rights arguably reinforces that the aims of recovery and full participation should, generally, not be associated with restrictions. Expanding principle 3 in the suggested manner is a reminder that in addition to compulsion and restriction being a last resort, the extent of any compulsion or restriction that is imposed must be minimised[6].

11. Reducing inequities of access and responding to the particular needs of individuals from marginalised groups in the community is woven throughout the draft objectives and principles. The Royal Commission's inquiries brought a further inequity into the open – that presently, compulsory Treatment Orders are sometimes used to determine access to services.[7] Consideration should be given to expanding principle 3 to confirm or make clear that access to services and supports must never be determined on the basis of a person's status as a voluntary or compulsory patient.

[6] An approach that arguably advances or is consistent with section(7)(c) of the Charter of *Human Rights and Responsibilities Act 2006.*

[7] Royal Commission into Victoria's Mental Health System, 2021, *Final Report,* State of Victoria, Melbourne, Volume 4, Chapter 32, 373 and 375.

Non-legal advocacy, supported decision making and information sharing

Non-legal advocacy

12. The Tribunal would welcome and value the involvement of non-legal advocates in hearings. Given non-legal advocates will potentially have been supporting a compulsory patient for an extended period of time (for example the roughly four week period between the making of an Assessment Order and the hearing), and with a focus on minimising or removing coercive interventions, it is envisaged they could make a critical contribution in hearings. In some matters a Treatment Order won't be made, but in those matters where they are, non-legal advocates can be part of the discussion that explores potential pathways to less restrictive treatment in the future.

13. Presently non-legal advocates do not attend Tribunal hearings and we understand this is due to resource levels and funding arrangements. Presumably this can be resolved given the future scale of non-legal advocacy services, and might be addressed through the proposed guidelines to be issued by the Chief Officer for Mental Health and Wellbeing.

14. Regarding statutory provisions that are needed to enable the involvement of non-legal advocates in hearings:

    - Section 184(3) of the current Mental Health Act is sufficiently broad to enable non-legal advocates to represent consumers and it could be replicated in the Mental Health and Wellbeing Act.

    - Consideration should be given to whether specific provision needs to be made to facilitate the sharing of information by the Tribunal with a person's non-legal advocate. One option that could be employed (although it doesn't address all aspects of information sharing) is the inclusion of a person's non-legal advocate in the list of people the Tribunal must notify of a hearing – contained in section 189(1) of the current Mental Health Act.

    - If non-legal advocates are to be involved in Tribunal hearings consideration will need to be given to what if any role they can have in applications to deny a person access to documents (presently made under section 191(2) of the current Mental Health Act). The Tribunal can provide further submissions on this issue if required.

Supported decision making

15. The Tribunal notes that the Mental Health and Wellbeing Act, or the regulations, will reflect or articulate the type of discussion and exploration that is to occur between a consumer and their treating team, with the aim of supporting them to make a decision about treatment. It will also set down obligations to document this process, and in particular, record the reasons or rationale for substitute treatment decisions that are contrary to a person's views and preferences.

16. As a record of the consumer's views and preferences, the reasoning of their treating team and (presumably in many cases) the contribution of the consumer's non-legal advocate and other support people, this information would be extremely relevant in any subsequent Tribunal hearing. However, it is important to note that given what the engagement paper describes as the intended content of these records, their use in Tribunal hearings will need clarification to avoid confusion about the relevance of capacity in relation to deciding whether or not to make a Treatment Order.

17. As part of the implementation of the Mental Health and Wellbeing Act the Tribunal would be keen to work with services to develop processes that would enable these records to be prepared and provided to the Tribunal in a way that reduces the amount of additional information or reports that need to be prepared for hearings.

18. The Tribunal also suggests consideration be given to including specific obligations in this framework in relation to any instance where ECT is administered on a compulsory basis pursuant to an Order made by the Tribunal. It is not uncommon for the person who is the subject of an application for an ECT Order to have been administered ECT on a compulsory basis in the past. Records of the previous course of ECT are variable in terms of their availability and quality, and even the best records tend to focus solely on clinical observations about the person's response to treatment.

19. The Tribunal's view is that particularly detailed records should be kept about the administration of compulsory ECT. In addition to recording clinical observations about the person's response to treatment, it is essential that they also record the person's subjective experience of treatment, any side-effects they have had, and their view on whether they would want to have ECT again in the future, and reasons for this preference. This shouldn't only happen in the immediacy of the inpatient unit where the person is treated with ECT, but also later in the community, to gauge medium to longer term responses to the treatment, and any shift in the person's preferences. This information would be invaluable if there was a future application, especially if it was made at a time when a person is unable to express their preferences.

Information sharing

20. Access to information in the lead up to and as part of Tribunal hearings can be a source of confusion and complexity. Based on our experience there are three matters the Tribunal wishes to highlight:

    i. Section 191 of the current Mental Health Act[8]

    A person who is the subject of a Tribunal hearing must be given access to any documents in the possession of the designated mental health service that are connected to the hearing at least 48 hours beforehand. The only exception to this is when the Tribunal grants an application to deny access to a document. An application

[8] If passed, clause 131 of the Crimes (Mental Health and Unfitness to be Tried) Amendment Bill 2020 currently before the Victorian Parliament will significantly alter section 191 of the current Mental Health Act, particularly by adding new subsections 191(5)-(8) around giving legal practitioners access to documents, including those documents that are the subject of an application to deny access to documents. However, the content of these proposed new provisions broadly reflects current practice as set out in the Tribunal's Practice Note 8 – Access to documents in Mental Health Tribunal hearings, available on under the publications/rules and practice notes tab of the Mental Health Tribunal's website <http://www.mht.vic.gov.au>.

can only be granted if the disclosure of information in the document may cause serious harm to the person who is the subject of the hearing, or another person.

As one of the proposed principles concerns 'providing consumers with access to their own information as soon as reasonably practicable after it is requested'[9], this would appear to expand access rights in that they do not depend on a consumer being the subject of a Tribunal hearing to 'crystalise', and can be exercised at any time, not just in the lead up to a hearing. Assuming this interpretation is correct at least two matters need to be considered and clarified –

a) The intersection between this expanded right of access and applications to the Tribunal to deny access to documents, especially as access may be requested when there is no Tribunal hearing on foot.

b) Whether the scope of a future version of section 191 can be narrowed down – if there is a free-standing right of access it may only need to articulate an obligation to provide access to documents being prepared for a hearing (that is, hearing reports), and existing documents that are being extracted and provided to the Tribunal in accordance with the Tribunal's practice note[10].

ii. 'Meaningful' access

To state the obvious, a right of access to information can be diminished if information that has been requested is provided in such a way that it is difficult to use or understand. The Tribunal does observe various impediments to meaningful access to information, including those outlined below.

a) The Tribunal as a user of information (that is for each hearing we require mental health services to provide extracts of relevant parts of a person's clinical file) encounters vastly different modes of extraction and provision. A number of services advise the Tribunal that their systems only enable information to be extracted in a format that is voluminous, not indexed, and in some instances not in chronological order. We can only assume that consumers seeking access to information may be presented with similarly impenetrable materials. Consideration should be given to the principles concerning information collection, use and sharing encompassing a responsibility to provide information in an accessible form when it is requested.

b) Some consumers experience personal barriers to meaningful access to information attributable to literacy skills, language and disability. Sometimes those barriers are overlooked or not accounted for when providing access to information. The principles (and also a future equivalent of section 191) should require relevant assistance to be provided to a person accessing their information.

c) As noted above, under section 191, a person must be given access to relevant documents at least 48 hours before a Tribunal hearing. This obligation is

[9] Department of Health, 2021, *Mental Health and Wellbeing Act: update and engagement paper,* State Government of Victoria, Melbourne, 20.

[10] Practice Note 8 – Access to Documents in Mental Health Tribunal hearings, available on under the publications/rules and practice notes tab of the Mental Health Tribunal's website <http://www.mht.vic.gov.au>.

satisfied where a person who has a hearing on Monday is given the documents on a Friday. For a person wanting to discuss the documents with a lawyer, advocate or other support person the fulfilment of this obligation is in reality less than satisfactory. Future timeframes for the provision of information prior to Tribunal hearings should be expressed as business days, being at least two business days prior to a person's hearing.

iii. Family violence

Details concerning family violence can be recorded in patient files and concerns have been raised with the Tribunal about situations where the patient is an alleged perpetrator and they access their file under section 191 of the current Mental Health Act. Recommendation 22 of the Family Safety Victoria Review of the Family Violence Information Sharing Legislative Scheme stated:

> *The Victorian Government should work with the Mental Health Tribunal to ensure that victim/survivor safety is prioritised as part of its processes and to avoid the risks of any adverse consequences arising from the Scheme. In particular it should communicate with the Mental Health Tribunal about the family violence risks associated with disclosing to perpetrator/applicants any part of their file which indicates that family violence risk information has been shared without their knowledge under the Scheme.*[11]

There have been discussions between Family Safety Victoria and the Tribunal, and further work will be done. While applications to deny access to documents under section 191 can offer a solution it is not ideal, it would be far better for practices to be in place that avoid the need for such applications. Whether it be in the Mental Health and Wellbeing Act itself and/or regulations, consideration should be given to principles or guidance governing the recording of information concerning allegations of family violence.

[11] Family Safety Victoria 2020, *Review of the Family Violence Information Sharing Legislative Scheme - Final Report*, Monash University, Melbourne, 148.

Compulsory assessment and treatment

The criteria for compulsory Treatment Orders

21. The Tribunal appreciates the very deliberate use of less stigmatised language throughout the final report of the Royal Commission may underpin the proposal to replace 'preventing serious deterioration in the person's mental or physical health' with 'preventing the person experiencing serious distress' in the future criteria for compulsory treatment'.[12] The Tribunal supports a shift in language but has a number of concerns about the use of the term *distress* as a legal test for the making of a Treatment Order.

    - Distress is an imprecise term not used in any other Australian mental health legislation, and even looking beyond mental health legislation, preliminary research has not identified any jurisprudence that would greatly assist in interpreting and applying the term if it were used in this way.

    - If the term is used to only include subjective distress there are a range of extremely serious presentations where a person will not be distressed by their mental health condition, for example a person experiencing catatonia or mania, or a person living with anorexia nervosa (although the interventions being provided will often be a cause of significant distress).

    - There is no indication that section 5(a) of the current Mental Health Act is to be significantly changed, as such it appears that it will continue to be the case that one of the future criteria will require decision makers to be satisfied that a person is experiencing symptoms of mental illness (defined by reference to categories of symptoms rather than diagnostically). If that is the case, consideration of a person's mental health should continue to be one aspect of the future version of section 5(b) of the current Mental Health Act.

    - Arguably distress has a very broad meaning that expands the range of circumstances that are regarded as falling within the scope of Treatment Orders.

22. Requiring any potential harm to either the person themselves or another person to be both serious and *imminent* is also problematic.

    - An imminence test could preclude Treatment Orders being used to facilitate earlier intervention to prevent harm from occurring. The Royal Commission rightly criticised the current inability of those who are not regarded as 'sick enough' (the so-called missing middle) to access the mental health system.[13] While compulsory interventions should be used as little as possible, relegating the use of Treatment Orders to crisis interventions where the crisis has already materialised, or is extremely close, has the potential to create a new cohort of people who aren't 'sick enough'. The Tribunal's view is that this could also contribute to the longevity of Treatment Orders in at least two ways. Firstly, compulsory engagement between a consumer and their treating team forged in a time of actual or near crisis, will often be more difficult to 'unwind' and transition to a voluntary engagement as the initial

[12] Department of Health, 2021, *Mental Health and Wellbeing Act: update and engagement paper,* State Government of Victoria, Melbourne, 26.

[13] Royal Commission into Victoria's Mental Health System, 2020, *Interim Report,* State of Victoria, Melbourne, 159.

circumstances are likely to be more distressing, possibly even traumatic. Secondly, if Treatment Orders can only be put in place at the time of actual or near crisis this has the potential to foster a very cautious approach to revocation – there is an incentive to keep a Treatment Order in place 'a little longer', rather than revoke it as early as possible.

- Imminence is not an absolute concept. If the relevant serious harm is repairable, deferring a compulsory intervention until the harm is imminent can seem reasonable. However, if the relevant serious harm is catastrophic, deferring action until it is imminent becomes problematic, especially if we are frank about the limited ability of any individual or process to accurately predict imminence.

- It should be noted the Tribunal is unaware of a Treatment Order ever having been made solely on the basis of immediate treatment being needed to prevent serious harm to another person. Where that is part of the reasoning it is alongside a conclusion that immediate treatment is also needed to prevent a serious deterioration in the person's mental health. Partly this is due to an awareness that this criterion can be stigmatising. Accordingly, if satisfied that immediate treatment is needed to prevent serious deterioration in the person's mental health, the Tribunal will often only address the issue of possible harm to others if it is seen as necessary in the circumstances. This approach is also reflective of what is presently (in the Tribunal's experience) the more significant problem with approaches to the current criterion, and that is the lack of specificity and supporting evidence in relation to assertions that immediate treatment is needed to prevent serious harm to others.

23. The term *last resort* is another that clearly reflects the language of the Royal Commission. The engagement paper is not explicit about whether this might replace the concept of *less restrictive means* that is used in section 5(d) of the current Mental Health Act. If that is under consideration it is potentially problematic. While the objective or principle of last resort works to convey a succinct and powerful message, as a treatment criterion it may attract some of the pitfalls identified in relation to imminence. In particular, how many interventions and for how long do they need to be tried to reach the point of last resort, potentially relegating a compulsory intervention to the point of acute crisis? Arguably the objective of last resort can be realised through a criterion expressed with greater specificity – see below at para 25.

24. When revising and redrafting the compulsory treatment criteria a useful question to consider is what type of discussion, deliberation and weighing of options the Royal Commission appears to contemplate as a means of achieving the objective of compulsory treatment as a last resort. This can also be informed by section 7 of the Charter given the compulsory treatment criteria should, as is the case currently, seek to ensure compulsory treatment is only used to impose 'reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'[14]. Critically, section 7 of the Charter requires thorough scrutiny of the proposed limitation (that is compulsory treatment) including its purpose, the importance of that purpose, the nature and extent of the

[14] As set out in Mental Health Tribunal 2020, *Royal Commission into Victoria's Mental Health System – Further submission from the Victorian Mental Health Tribunal,* Melbourne, 8, it has been confirmed that the involuntary treatment framework contained in the former *Mental Health Act 1986,* and by extension the compulsory treatment provisions of the current Act, engage and limit a number of rights protected under the Charter, but the framework does satisfy a reasonable limitations analysis conducted in accordance with section 7(2) of the Charter. See passages cited in that submission from *Kracke v Mental Health Review Board & Ors (*General) [2009] VCAT 646 (revised 21 May 2009), [784]; *and Kracke v Mental Health Review Board & Anor (No 2)* (General) [2009] VCAT 1548, [15].

limit, the relationship between the limit and its purpose, and less restrictive means (reasonably available) to achieve the purpose.

25. To this end the compulsory treatment criteria of the Mental Health and Wellbeing Act should, wherever possible, seek to promote a consideration of options that pull in opposite directions, and require an answer that explains how those competing consideration were weighed up, as opposed to a simple yes or no conclusion. Two options to achieve this include the following.

    i. A criterion focused on whether treatment is currently required to maintain or promote the mental health and wellbeing of the person, or to prevent harm to another person. This criterion could be informed by a non-exhaustive list of relevant considerations including the 'downside' of treatment such as side effects of medication and the negative impact of restrictions on autonomy. To prevent a paternalistic approach to what constitutes wellbeing, the list of relevant considerations could embed the principle of recovery, and the determinants of 'full and effective participation in society'[15] as central to this assessment.

    ii. A criterion that requires a response to the question – how has it been determined that the person's preferred or proposed approach to maintaining their mental health and wellbeing and preventing harm to another person is insufficient or ineffective? The current section 5(d) focuses on what the person will or won't accept on a voluntary basis, which has a tendency to frame pathways to less restrictive treatment primarily in terms of the person changing their position and agreeing to what is being proposed. Re-framing the question so that the focus is on explaining why the person's preferences cannot be adhered to reorients not only the decision to be made at a particular point in time, but also the pathway to a different decision or outcome in the future. Arguably this is a better reflection of section 7 of the Charter and its emphasis on scrutinising a proposed restriction on rights. Such a criterion could also be informed by a list of non-exhaustive considerations. These could encourage flexibility in engagement between consumers and their treating team. For instance, the approach to the current section 5(d) often frames the person's preferred approach as a hypothetical alternative – albeit based on their stated intentions. This alternative approach could encourage not only discussions about, but consideration of trialling the person's preferred approach (in whole or part) while a Treatment Order is still in place.

Case study

The following case study is based on actual hearings. Its focus is not the final outcome, rather it has been provided to illustrate how the suggested approach to revised criteria could better facilitate the exploration and weighing up of competing considerations.

F has had episodes of treatment for his mental health over many years, primarily on a compulsory basis. During that time F's treating teams have recorded ongoing psychotic symptoms, most commonly, paranoid delusions that have significantly affected his behaviour and decision making. The last six years have been relatively settled. F has not been admitted to hospital and has received ongoing treatment under a series of Community Treatment Orders. F's preference is to

[15] Royal Commission into Victoria's Mental Health System, 2021, *Final Report,* State of Victoria, Melbourne. This wording is taken from guiding principle 1, Volume 1, Chapter 2, figure 2.8, 76.

minimise contact with his treating team, so appointments and reviews are as infrequent as possible. Treatment centres around fortnightly administration of injectable medication.

F's primary focus is on having his Community Treatment Order revoked. In his hearing he vividly describes the distress the Order and treatment cause him. F's treating team acknowledge that in all their interactions with F this tends to be the sole topic of conversation. They acknowledge his distress, but also maintain that even with treatment F continues to experience symptoms, however not at an intensity that significantly affects his day to day life, but they think the likelihood of a serious relapse is high. F, his wife and his adult son all agree that apart from his distress regarding treatment, home life is reasonably settled, and F is actively engaged with his church. F is unambiguous: if the Community Treatment Order is revoked he will cease treatment immediately. He is equally clear that he does not think any harm could flow from this decision. F's wife explains that while they are very concerned, the family support F's desire to have the Community Treatment Order revoked as they know how distressing it is for him.

Obviously there are a myriad of things to consider in a case such as F's; however, where they fit under the current criteria is far from straightforward. On the one hand it is perverse to suggest F's subjective experience of treatment is not relevant, but it is also accurate to say there is not a clear 'hook' in the criteria for compulsory treatment that firmly embeds it as a factor that informs whether or not to make a Treatment Order. A very broad approach to section 5(b) and the definition of treatment might incorporate it, but frankly, it shouldn't require creativity to achieve this end. Even the central focus of least restriction in section 5(d) struggles because that section essentially asks, 'will F receive immediate treatment on a voluntary basis?' and F himself is clear the answer is no, leaving limited room for further deliberation. Criteria along the lines proposed above at para 25 would both enable and compel the weighing and balancing of competing considerations that F's circumstances demand.

A multi-faceted exploration of F's mental health and wellbeing ensures that his subjective experience of a Treatment Order and treatment (bearing in mind his distress about each, though intertwined, is distinct) is equivalent in relevance to the possibility of a relapse of his illness and what that might cause. By asking 'why can't we work with F's preferences?', while his stated intentions remain relevant, shifting from an almost exclusive focus on what he will or won't do means his broader context (including, for example, the mitigating factor of his family's support) is incorporated into the deliberation. None of this is to suggest revised criteria make for an easier decision, but they do facilitate a richer, balanced and more rigorous decision-making process.

Other matters relating to the making of compulsory Treatment Orders

Discretion to not make an Order

26. Reference is made in the engagement paper to the possibility of the Mental Health and Wellbeing Act allowing the Tribunal 'to make, or not make, a treatment order when the criteria for compulsory treatment are met'.[16] The Tribunal's view is that the criteria for compulsory treatment should capture and require consideration of all the matters relevant to the making

[16] Department of Health, 2021, *Mental Health and Wellbeing Act: update and engagement paper,* State Government of Victoria, Melbourne, 27.

of a Treatment Order, and if the decision is that those criteria are met, a Treatment Order must then be made.

27. An open-ended discretion that comes into play after consideration of the criteria for compulsory treatment would be a source of uncertainty, confusion and inconsistency. As noted above, the Tribunal strongly supports criteria that require consideration of the reasons for not making a Treatment Order, and for the weighing of options and alternatives to be articulated clearly. To put it a different way, however they are formulated, the criteria for compulsory treatment should permit, and indeed compel, a weighing up of all relevant considerations. When this is done properly there should be no further role for an open-ended discretion.

Determining the duration of an Order

28. While not suggesting this should be the sole basis of determining whether the Mental Health and Wellbeing Act should reduce the maximum duration of a Treatment Order, the Tribunal notes that at least during the initial period of the Mental Health and Wellbeing Act's operation, while service reforms are still being designed and implemented, a reduction in maximum duration has the potential to lead to significantly more hearings. This has implications not only for the Tribunal but for all parties and hearing participants.

29. From the Tribunal's perspective, whatever the specified maximum duration, the Mental Health and Wellbeing Act should articulate (non-exhaustively) the considerations that are relevant to determining the duration of a Treatment Order. Key amongst these considerations should be the plan for the treatment and support that is to be provided to a person pursuant to a Treatment Order. To this end the Tribunal refers to its second submission to the Royal Commission that suggested the Tribunal's consideration of a proposed treatment and support plan to inform a decision about the duration of a Treatment Order could include examining the following:

    - participation of the consumer and their support people in the development of the plan
    - the breadth of treatment and supports
    - coordinated or 'joined-up' provision of services and supports
    - identification of the consumer's specific preferences that the plan proposes to override with an explanation of why each is necessary
    - a collaborative pathway to less restrictive treatment.[17]

Annual targets

30. Following on from the issues noted in paras 7-8 and needing to ensure the discretion of the Tribunal is not fettered, it could be worthwhile to make clear that the annual targets for reducing the use and duration of compulsory treatment set down by the Chief Officer for Mental Health and Wellbeing do not apply to determinations by the Tribunal.

[17] Mental Health Tribunal 2020, *Royal Commission into Victoria's Mental Health System – Further submission from the Victorian Mental Health Tribunal,* Melbourne, 13.

Tribunal conferences

31. In our second submission to the Royal Commission the Tribunal proposed the use of pre-hearing conferences as part of an improved process for handling matters identified as complex. The relevant parts of that second Royal Commission submission are reproduced as Appendix A to this submission.

32. The Tribunal welcomes the consideration of conferences as part of the Mental Health and Wellbeing Act but is concerned that what is proposed in the engagement paper is too broad. The Tribunal favours a more contained approach at this point in time.

33. In excess of 2,500 matters each year could fall within the scope of what is suggested in the engagement paper. While we clearly think there is a potential role for conferences we should also keep in mind that (as far as the Tribunal is aware) this mechanism has not been employed in any other mental health jurisdiction. This suggests that initially conferences should be utilised strategically and somewhat sparingly – effectively a pilot to assess their ability to foster meaningful progress and change – before they are deployed more broadly.

34. Beyond the possible scope of what is proposed in the engagement paper, there is also a question of timing and process. The Tribunal's view is that a conference generally needs to happen well in advance of a hearing to determine an application for a further Treatment Order (hence our proposal that its relevance and use be identified and planned for from the time a Treatment Order is made). The closer a conference is to the hearing the more difficult it becomes to distinguish between their respective purpose, and the matters for exploration in each. Also, time is needed between a conference and the later hearing for options to be developed and potential, alternative outcomes to emerge.

35. The Tribunal is keen to contribute to further exploration of how a conferencing function could be conceptualised and framed within the Mental Health and Wellbeing Act.

Promoting cultural change to support the dignity of risk

36. In its submissions to the Royal Commission and more broadly the Tribunal has commented extensively on risk[18], and is very supportive of a broad strategy being employed to develop a better community understanding of risk and risk management, and to support those with decision making responsibilities to make less risk-averse decisions. This needs to encompass extremely complex and difficult messages, including the frank acknowledgement that coercive responses do not eliminate risk, and in fact have risks of their own.

37. The engagement paper refers to the Act or regulations being the vehicle for this – the Tribunal's view is that both are needed. Given the significance of this issue the Tribunal believes the Act itself needs to set the parameters by articulating key principles that can then be developed further in the regulations and a broader suite of resources.

[18] See, for example, Ibid, 3.3; and Mental Health Tribunal 2019, *Royal Commission into Victoria's Mental Health System – Formal submission from the Victorian Mental Health Tribunal,* Melbourne, 3.1.3.

38. In our second submission to the Royal Commission the Tribunal used the provisions in the current Mental Health Act covering capacity as a blueprint or model for expanded legislative guidance regarding the dignity of risk:

> *It is instructive to compare the Act's approach to dignity of risk and how it addresses capacity. Both dignity of risk and capacity can be 'flashpoints' for oppositional and stalled discussions. There are parallels between the polarities of "I have capacity to make this decision / I say you don't have capacity" and "I want to take this risk / I say the risk is too great". An important difference is that whereas the Act enshrines the dignity of risk principle but provides nothing further, in relation to capacity it provides a framework that can be used to advance discussions and the exploration of different perspectives. Specifically, the Act:*
>
> - *Sets down a rebuttable presumption of capacity (section 70(2)).*
> - *Articulates guiding principles each of which convey a critical message regarding community expectations concerning the assessment of capacity (section 68(2)).*
> - *Defines four domains of capacity that help bring rigour and specificity to capacity assessments (section 68(1)).*
>
> *A similar approach could be employed in relation to dignity of risk in order to foster better understanding of the principle and meaningful exploration of what it means in individual situations. Guiding principles and considerations relevant to delineating between reasonable and unreasonable risks could include (again these are not in statutory form):*
>
> - *Recognising that setbacks can be educative and have a legitimate place in recovery.*
> - *An essential parallel to the preceding point is to recognise that setbacks do not mean earlier, non-coercive decisions or responses to risk were wrong, provided those decisions were made after careful consideration of all relevant factors.*
> - *Guidance on how to scrutinise risks thoroughly, in particular the need for clarity and specificity about the grounds for concern, the nature of the risk, who it affects, and potential short and long term consequences, including on a person's future participation in community life.*
> - *Emphasising the need to identify and consider protective factors and mitigations other than compulsory treatment.*
> - *Acknowledging that coercive responses to risk are not risk free and in fact carry risks of their own; and furthermore, they are not guaranteed to work – mental health relapses can and do occur even when people are receiving treatment, including compulsory treatment.*[19]

39. In essence what the Mental Health and Wellbeing Act should seek to do is foster an environment in which a high bar is set in relation to the rigour of decision making – that is risk needs to be thoroughly considered and all relevant evidence sought out and competing considerations weighed up – but at the same time dismantle the impossible bar of predicting outcomes and controlling future events.

[19] Mental Health Tribunal 2020, *Royal Commission into Victoria's Mental Health System – Further submission from the Victorian Mental Health Tribunal,* Melbourne, 12.

Housekeeping amendment

Variation hearings under section 58(5) Mental Health Act

40. If the Mental Health and Wellbeing Act enshrines the same or similar scheme of Treatment Orders and hearings to those of the current Mental Health Act the Tribunal requests a correction of what appears to be an error in section 58(5) regarding what are called 'variation hearings'.

41. The Mental Health Act requires a hearing to be held when a person who was on a Community Treatment Order is brought back into hospital following an authorised psychiatrist's decision (made under section 58(1) and (2)) to vary the person's Community Treatment Order to an Inpatient Treatment Order. The Mental Health Act strikes a balance and only requires a hearing to occur if the person spends an extended period of time in hospital.

42. Section 58(5) states:

> *Within 28 days after a person is made subject to an Inpatient Treatment Order that was varied to the Inpatient Treatment Order from a Community Treatment Order under subsection (1)(c), the Tribunal must conduct a hearing to determine whether to make a Treatment Order or revoke that Inpatient Treatment Order under section 55 if, at the end of that 28 day period, the person remains subject to the Inpatient Treatment Order.*

43. Clearly the provision is unclear as to when a variation hearing is to be held – as a matter of practice the Tribunal adopts the cautious approach of holding such hearings within 28 days of an Order being varied. The ambiguity of section 58(5) should be resolved and the Tribunal can provide further input regarding the alternative solutions.

Appendix A: Extract from the Tribunal's second submission to the Royal Commission addressing pre-hearing conferences[20]

3.5 Case management of complex matters by the Tribunal

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

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

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

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

- The views of the patient and those who support them.

[20] Ibid, 3.5.

- Duration of treatment pursuant to an ITO.
- Total duration of compulsory treatment.
- Treatment history, including a person's experience of voluntary treatment.
- Multiple agencies and services needed to facilitate less restrictive treatment.

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

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

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