

**Mental Health
Tribunal**



Royal Commission into the Victorian Mental Health System

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

June 2019

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MENTAL HEALTH TRIBUNAL SUBMISSION

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LIST OF ABBREVIATIONS USED IN THIS SUBMISSION	
Act	<i>Mental Health Act 2014 (Vic)</i>
AMHS	Area Mental Health Service
AO	Assessment Order
AOD services	Alcohol and Other Drug treatment services
Board	Mental Health Review Board
Charter	<i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>
CTO	Community Treatment Order
DMHS	Designated Mental Health Service
ECT	Electroconvulsive Treatment
ITO	Inpatient Treatment Order
NDIS	National Disability Insurance Scheme
OCP	Office of the Chief Psychiatrist
ODS	Operational Data Store
SECU	Secure Extended Care Unit
STO	Secure Treatment Order
TAG	Tribunal Advisory Group
TO	Treatment Order
Tribunal	Mental Health Tribunal
TTO	Temporary Treatment Order

A NOTE REGARDING LANGUAGE

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

CASE STUDIES

The case studies used in this submission are based on hearings conducted by the Mental Health Tribunal. They have been chosen to demonstrate systemic issues. All case studies have been de-identified, including the use of randomly allocated aliases and in some instances the person's gender has been changed.

FOOTNOTES

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

EXECUTIVE SUMMARY

Since commencing operation on 1 July 2014, the Mental Health Tribunal has conducted more than 34,000 hearings. These hearings have provided us with a unique and privileged insight into the experiences of mental health consumers who receive compulsory treatment through Victoria's clinical mental health services, as well as that of the family and friends who support them. We see many positive stories of recovery, and examples of effective, collaborative treatment. However, far too often we observe how the mental health system fails to provide the treatment and support that people both need and want.

Our work also brings us into daily contact with the highly committed clinical and administrative staff that work within the mental health system. Despite enormous pressures associated with crushing case-loads and increasing demand, they strive to support consumers and carers. But the reality is, the system that they work in is neither equipped nor structured to enable staff to always provide the best possible care.

Whether we do in fact have a mental health system – as the term 'system' would generally be understood – needs to be tested. An essential feature of a system is that its component parts work in unison and complement each other. At both a micro and macro level this is not the case. Different arms within what is meant to be one service work in silos, and this is replicated at a broader level, in that different services do not communicate or collaborate effectively. This directly impacts on the quality of treatment and support provided to individuals. It can also have profound impacts on the levels of restriction individuals are subject to, and the adequacy of service responses to individuals with complex needs. Indeed, the situation of individuals with complex needs not only demonstrates how difficult it is to achieve collaboration across different services, it suggests that services will at times actively avoid collaboration. The response to individuals whose complex needs arise from the severe and enduring nature of their mental illness also highlights, and is arguably partly driven by, the tragic reality that in some cases, there are no truly satisfactory options available within the current system.

The Tribunal observes numerous consequences of the profound gulf between the level of demand for treatment and support, and the level of resources provided to services to meet that demand. Of particular concern is how this has impacted the implementation and intended operation of the *Mental Health Act 2014* (the Act). The Act was intended to be a catalyst for reform. It clearly encompasses a bio-psychosocial conceptualisation of mental health and responses to mental illness. It sought to promote supported-decision making, less restrictive treatment, autonomy, dignity, holistic care and the meaningful involvement of carers. In some cases these principles and objectives are realised. However, at a systemic level, what the Act's first five years of operation demonstrates most potently is that changing the law cannot by itself change the system to which it applies, when that system is not resourced to meet the expectations enshrined by law reform. The Act's relative failure, or at best marginal success, in reducing levels of compulsory treatment also demonstrates that for real change to be achieved, the broader community (i.e. not just the constituent parts of the mental health system) needs to be part of a sophisticated conversation about how we respond to risk.

Not only have the reforms envisaged by the Act stalled, arguably one of the tasks for which the Act is primarily used is a purpose for which it was not designed – namely deciding how to allocate scarce resources. The implications of this are significant. Most concerningly it results in inequality of access across voluntary and compulsory patients, as well as the illogical allocation of resources.

A person's status under the Act should only be about defining the legal relationship that exists between that person and her or his treating team at a point in time, it should not determine the scope or elements of care and support provided to individual consumers. Restricted autonomy should not be a hidden cost of attaining access to services, and voluntary engagement should not limit the availability of intensive, even assertive support. However, in a system that is being constantly challenged to meet increasing demand without adequate resources these hidden costs and perverse incentives are real.

Using the Act as a resource allocation tool also appears to have resulted in a profound distortion of how it is intended to respond to mental health crises. The Tribunal frequently observes an inverted bar governing access to and exit from compulsory treatment. Put simply, voluntary consumers must become extraordinarily unwell before services will initiate a compulsory intervention. However, for compulsory patients, services can be reluctant to switch to voluntary

engagement even after significant recovery. This illogical approach to the allocation of resources ignores the fact that on its own terms the Act has a focus on preventing mental health crises, and instead positions compulsory interventions under the Act as a response that 'mops up' after a crisis has occurred.

While acknowledging that so many of the deficiencies with the current system are a consequence of inadequate resourcing, the Tribunal's view is that resourcing does not fully explain the current predicament, and as such, increasing resources cannot be the sole solution. Arguably one of the less obvious consequences of years of under-resourcing is an erosion of culture. This is evidenced by many of the significant issues that are the focus of this submission. One such example is the lack of collaboration between separate parts of the current system referred to above. The Tribunal recognises that when resourcing is inadequate cross-service collaboration may be difficult and slow, but abandoning efforts to collaborate points to a more fundamental and profound deficit. The erosion of culture is also evidenced by a number of 'smaller things' frequently observed by the Tribunal and that are described in this submission.

The mental health system of the future needs to be sustainable and capable of continued evolution so it can respond to the changing needs and expectations of consumers and carers. To achieve this aim, it must be underpinned by a culture of patient-focused, empathic service delivery. Such a culture must be consistent across the systems' constituent parts, robust and monitored proactively. That culture can be articulated now, and steps taken to begin to embed it so that there is a solid foundation in place to support the service system that emerges from the recommendations of this Royal Commission.

PART A: INTRODUCTION AND CONTEXT

1. Introduction

The Mental Health Tribunal (Tribunal) was established under the *Mental Health Act 2014* (the Act) and commenced operation on 1 July 2014, replacing the former Mental Health Review Board (Board). The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness. The Tribunal has a range of functions, the most relevant to the Royal Commission being:

- determining whether to make (or revoke) a Treatment Order (TO) that requires a person to have compulsory treatment for a mental illness either in an inpatient setting, or while living in the community;
- reviewing Secure Treatment Orders (STO) that require a person who is either on remand or serving a custodial sentence, to have compulsory inpatient treatment for a mental illness at Thomas Embling Hospital; and
- determining whether to make an Electroconvulsive Treatment Order that authorises the use of electroconvulsive treatment (ECT) in the treatment of adults who lack capacity to provide informed consent (whether voluntary, compulsory, security or forensic patients), and in any instance where the person being treated is less than 18 years old.

In 2018/19 the Tribunal will conduct more than 8,000 hearings. The majority of these are conducted in-person which means the Tribunal visits 57 mental health inpatient units and community clinics across Victoria on a regular basis. Consumers and carers / support people are always encouraged to attend hearings, in 2017/18 consumers did so in 57% of hearings, carers / support people attend in 27%. (Raising attendance levels of consumers and carers is a constant focus of the Tribunal and an issue we are seeking to address through a broad range of initiatives described below at Part B – 4.1.1)

1.1 This submission

The Tribunal does not presume to speak for consumers and carers, but through the performance of our functions we become the custodian of innumerable stories of peoples' engagement with the mental health system, when that engagement is with clinical mental health services on a compulsory basis. This provides the Tribunal with a unique perspective and substantial body of evidence on which to base this submission. However, it does not mean we have knowledge of all aspects of the mental health system, or all the matters being examined by the Royal Commission, therefore this submission only responds to some of the questions posed by the Royal Commission.

This submission covers the following matters:

- the reform objectives that underpinned the passage of the *Mental Health Act 2014*;
- the Tribunal's approach to the performance of its functions;
- the legal framework for compulsory treatment;
- the legal framework applicable to electroconvulsive treatment;
- response to questions; and
- key statistics, including trends over the Act's first five years of operation.

2. The *Mental Health Act 2014* – a catalyst for reform

The current Act replaced the former *Mental Health Act 1986* which was revolutionary at the time it was passed, but on any measure had become significantly dated. The Act was a product of several years of intense consultation with consumers, carers and service providers; a process

that was both prompted and informed by local and international developments in human rights. Domestically, Victoria was the first Australian state to enact human rights legislation – the *Charter of Human Rights and Responsibilities 2006* (the Charter). This was the same year the United Nations adopted the *Convention on the Rights of Persons with Disabilities* which marked a dramatic shift in the conceptualisation and understanding of the human rights of people with psychosocial disabilities.

The Act was also ‘catching up’ with a service system that had undergone profound changes and already adopted very different paradigms of service delivery, in particular a commitment to recovery-oriented practice. Reforms sought to embed these changes – taking them out of the optional or aspirational realm and making them obligatory, while also seeking to push these changes further.¹

The reform objectives are reflected most succinctly in the mental health principles set down in section 11 of the Act. In summary the principles emphasise:

- minimising restrictions on people receiving mental health treatment;
- promoting recovery and community participation;
- maximising patients’ participation in decision making i.e. supported decision making;
- holistic care (including responding to both physical and mental health needs, and recognising and responding to the particular needs of individuals from specific groups);
- that people have the right to make decisions involving a degree of risk, including decisions that others might regard as unwise; and
- recognition of the role of carers and their inclusion in decision making.

All individuals and entities exercising powers or performing functions under the Act are required to have regard to the mental health principles – this includes the Tribunal.² In most if not all cases those entities will also be public authorities with obligations under the Charter. At first glance this may appear to give rise to complexity and difficulty associated with understanding and adhering to multiple legal obligations. However, there is an overall coherence, and judicial consideration of these matters supports the view that decisions made on the basis of robust application of the relevant legal tests in the Act, and thorough consideration of the mental health principles, will generally mean there has been appropriate scrutiny of decisions in accordance with the human rights protected under the Charter.³

An issue that was constantly raised in the community consultations regarding the Act was Victoria’s extraordinarily high levels of compulsory treatment. A key expectation of the Act was that it would drive a reduction in the rates of compulsory treatment. This expectation has not been met to any significant extent, and this issue is addressed in greater detail below (Part B – 3.1).

3. The Tribunal’s approach to the performance of its functions

When the Tribunal commenced operation, we understood that there were high expectations that we would be focused on promoting the rights of consumers and carers. These extended beyond diligent performance of our decision-making functions, to include the expectation that all aspects of our operation and our culture would reflect, embed and promote the principles enshrined in the Act.

A key initiative developed in response to this expectation was the adoption of a framework to conduct solution-focused hearings. This framework draws upon the theories and practice of therapeutic jurisprudence, non-adversarial justice and problem-solving courts. A solution-focused approach is not about miscasting the Tribunal as a source of solutions, but rather about recognising that hearings can be conducted in a manner that enables and encourages participants to discuss, identify and commit to solutions or future actions. A solution-focused

¹ ‘The power to restrict a person’s rights, such as to provide compulsory treatment or to limit a person’s freedom of movement, brings with it an obligation to ensure that any restrictions can be justified, are proportionate and include effective oversight and safeguards. The bill establishes a comprehensive and integrated suite of oversight mechanisms and safeguards to protect the rights of patients’.
Mental Health Bill 2014, Second Reading Speech, House of Assembly, Minister Wooldridge, Thursday, 20 February 2014, p. 473.

² Section 11(3).

³ See for example *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, paras 66-67, 93, 99, 101, 104, 250-251, 256.

approach is based on the premise that the best outcomes are achieved when hearing participants are key players in the formulation and implementation of plans to address underlying issues. An assumption at the core of solution-focused hearings is that while a TO may need to be made at a specific point in time, compulsory treatment should never be regarded as the norm or permanent arrangement for a person, and there should always be a pathway to voluntary engagement – even if that pathway is only tentative or beginning to be articulated. In other words, solution-focused hearings seek to include a sense of hope for the future.

Solution-focused hearings are also one of the ways in which the Tribunal seeks to embed the mental health principles within its operations. 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, the 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.

A lynchpin in the operation and evolution of the Tribunal was the establishment of a dedicated consumer and carer engagement role that is part of both the Leadership and Governance groups in the Tribunal, meaning that person plays an equal and critical role in both strategic and operational decision making in the Tribunal. In addition, a significant focus of that role has been the establishment and facilitation of our Tribunal Advisory Group (TAG), comprising consumers, carers and members of the lived-experience workforce. There is a close and extremely effective working partnership between the TAG and the Tribunal. None of our service improvement initiatives over the past five years could have been achieved without the TAG. Some initiatives would never have been thought of, others might have been thought of and pursued, but the end results would not be close to those achieved in partnership with the TAG.

The Tribunal has also sought to foster effective working relationships with mental health service providers. Each service has a dedicated liaison member who, alongside relevant Registry staff, acts as a key point of contact to ensure administrative arrangements for hearings operate effectively, and if issues do arise they are resolved as quickly as possible and ideally at a local level. The Tribunal also delivers education sessions to staff in mental health services on an annual or biannual basis. The focus of these sessions is on the principles of the Act, and how to prepare for and participate in a solution-focused Tribunal hearing.

4. The Legal Framework for Compulsory Treatment

In terms of caseload, the most significant function of the Tribunal is to determine whether a person should continue to be on an Order compelling them to have treatment for a mental illness. Specified events give rise to an obligation on the Tribunal to conduct a hearing concerning a TO:

- an authorised psychiatrist placing a person on a Temporary Treatment Order (TTO), these Orders operate for up to 28 days and the Tribunal must conduct a hearing within that time to decide whether to revoke the TTO or make a TO⁴;
- when a TO previously made by the Tribunal is approaching its expiry date an authorised psychiatrist can apply to the Tribunal for a further TO to be made and subject to a limited adjournment power, the application should be determined before the expiry of the original TO⁵;
- a person who is subject to a TTO or TO can at any time make an application for the Order to be revoked, the hearing of the application needs to occur as soon as practicable. There is no limit on the number of applications that can be made⁶; or
- if a person on a TO who has been receiving treatment while living in the community is brought into hospital to receive treatment as an inpatient for an extended period, the Tribunal must conduct a hearing to determine whether a TO should remain in place. A

⁴ Sections 53 and 55.

⁵ Section 54.

⁶ Section 60.

hearing is listed and finalised within 28 days of their admission but is not required (and therefore does not proceed) if they are discharged from hospital beforehand.⁷

4.1 Criteria for compulsory treatment

In any hearing regarding a TTO or TO the Tribunal's role is to determine whether the criteria for compulsory mental health treatment set out in the Act apply to a person. If the criteria do apply the Tribunal must make a TO. If the criteria do not apply the Tribunal must revoke the current Order and the person immediately becomes a voluntary patient, meaning they have full liberty to decide whether to have treatment. The criteria for compulsory mental health treatment are set out in section 5 of the Act and are:

- the person has mental illness;
- because the person has mental illness, the person needs immediate treatment to prevent serious deterioration in the person's mental or physical health, or serious harm to the person or another person;
- the immediate treatment will be provided to the person if the person is subject to a TO; and
- there is no less restrictive means reasonably available to enable the person to be immediately treated.

For the purposes of making an Order, the Tribunal must, to the extent that is reasonable in the circumstances, have regard to several factors, including:⁸

- the person's views and preferences (including those expressed in an advance statement) about the 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;
- if they have one, the views of the person's nominated person or their guardian;
- the views of the person's carer, if the Tribunal is satisfied that making the Order will directly affect the carer and the care relationship;
- the views of a parent if the person is under the age of 16 years;
- the views of the Secretary of the Department of Health and Human Services (Secretary) if the person is the subject of a custody to Secretary order or a guardianship to Secretary Order.

4.2 Determination of the setting and duration of a Treatment Order

When the Tribunal makes a TO it must also determine the setting of the Order, that is whether it is a Community Treatment Order (CTO) or an Inpatient Treatment Order (ITO), and the duration of the TO.⁹

The Tribunal may only make a person subject to an ITO if the Tribunal is satisfied that treatment of the person cannot occur within the community. Any TO for a person under 18 years old can have a maximum duration of three months; however, for adults an ITO can have a maximum duration of six months, while the maximum duration of a CTO is 12 months.¹⁰ The Tribunal has always been very clear that the maximum durations of TOs set out in the Act are not default durations but rather the duration of an Order must reflect the circumstances of the individual patient.

4.3 Decisions regarding the specific treatment/s that will be provided pursuant to a Treatment Order

Apart from ECT that is being proposed for a person who is unable to provide informed consent or is under 18 years of age, the Tribunal does not decide what treatment will be provided to a patient (such as the type of medication or dosage levels). In relation to treatment decisions, the Act envisages an ongoing dialogue between a patient and their treating team; however, a patient's treating psychiatrist can direct treatment pursuant to an Order.¹¹

⁷ Section 58.

⁸ Section 55.

⁹ Sections 55 and 57.

¹⁰ Section 57.

¹¹ Sections 71-73.

This does not mean the Tribunal does not have an interest in or avoids discussion about treatment, on the contrary there will be significant discussion about these issues in hearings. In the context of solution-focused hearings the Tribunal frames its role or interest in treatment as being one of constructive inquiry and clarification:

- given the Tribunal is the entity that makes the TO that compels a person to have treatment we have a legitimate interest in what treatment is proposed, and where appropriate exploring treatment challenges or gaps;
- the meaningful incorporation of the mental health principles in Tribunal hearings necessitates the exploration of treatment issues; and
- a person's views about medication, the method of administration and side effects will be relevant to whether the criteria for making a TO are satisfied.

4.4 Compulsory treatment for prisoners and people on remand

The Secretary to the Department of Justice and Community Safety can, on the recommendation of an authorised psychiatrist, place a prisoner or remandee on a STO which means they will receive compulsory treatment for a mental illness.¹² Under current arrangements this can only be provided on an inpatient basis at Thomas Embling Hospital.

In contrast to its role as a primary decision maker regarding TOs, the Tribunal performs a review function in relation to STOs. Within 28 days of a person being admitted to Thomas Embling Hospital on an STO the Tribunal must conduct a hearing to review whether the criteria for an STO still apply to that person. These criteria are set down in section 276(1)(b) of the Act and are identical to the criteria for compulsory treatment in section 5 of the Act.

If the Tribunal decides the criteria do apply it confirms the STO and the person remains at Thomas Embling Hospital and will continue to receive compulsory treatment. The Tribunal must continue to conduct periodic reviews at intervals of no more than six months for as long as the STO remains in place.¹³ If at any point the Tribunal or the person's treating psychiatrist decides the criteria no longer apply to the person, they will return to the corrections system and any further treatment will be on a voluntary basis.¹⁴ A person subject to an STO can at any time make an application to the Tribunal for the Order to be revoked and there is no limit on the number of applications that can be made.¹⁵

5. The Legal Framework Applicable to Electroconvulsive Treatment

The second reading speech for the Act referred to the ongoing debate and controversy related to ECT.¹⁶ This is a key reason for ECT being subject to specific regulation¹⁷ and, in contrast to the former Board which had no role in relation to ECT,¹⁸ the Tribunal was vested with a range of

¹² Section 276.

¹³ Section 279.

¹⁴ Section 280.

¹⁵ Section 278.

¹⁶ Electroconvulsive treatment (ECT) is an effective treatment for severe depression and some other mental illnesses. Nevertheless, feedback from the community consultation processes showed that the community expects greater oversight of the performance of ECT on:

- Patients receiving compulsory treatment subject to an order under the bill; and
- People under 18 years of age.

ECT is a treatment rarely given to young people, but the clinical advice is that it may be the most appropriate treatment in a limited number of circumstances. It is for this reason the government has not prohibited its use but will require any ECT for people under 18 years of age to be approved by the Mental Health Tribunal.

Mental Health Bill 2014, Second Reading Speech, House of Assembly, Minister Woodbridge, Thursday, 20 February 2014, p. 475.

¹⁷ Neurosurgery for mental illness (NMI) is also regulated under the Act – see Part 5, Division 6, sections 100-104. NMI can only be used in the treatment of a person who has provided written consent in writing. NMI cannot proceed without the approval of the Tribunal. All NMI applications received by the Tribunal have concerned voluntary patients.

¹⁸ Under section 73(3) of the *Mental Health Act 1986*, if an involuntary, security or forensic patient was incapable of giving informed consent ECT could be performed if the authorised psychiatrist was satisfied that ECT had clinical merit and was appropriate; having regard to any benefits, discomforts or risks it should be performed; any beneficial alternative treatments have been considered; and if it was not performed the patient would likely suffer a significant deterioration in their physical or mental condition. All reasonable efforts had to be made to notify the patient's guardian or carer of the proposed performance of ECT.

responsibilities. Any adult who is receiving treatment for a mental illness, whether on a voluntary basis or pursuant to an Order, and who has decision making capacity, can consent to ECT and this can proceed without any involvement of the Tribunal. However, the Act requires the Tribunal to determine whether ECT can be used as part of the treatment provided to:

- compulsory, security or forensic patients if their authorised psychiatrist considers they do not have capacity to give informed consent¹⁹;
- voluntary adults if their psychiatrist considers they do not have capacity to give informed consent²⁰; or
- any person under the age of 18 (whether they are a patient or receiving treatment on a voluntary basis).²¹

Applications to the Tribunal for an ECT Order must be finalised within five business days, the Act also makes provision for applicant psychiatrists to request an urgent hearing.²² If the Tribunal decides to make an ECT Order it must also determine an authorised number of treatments (up to a maximum of 12), and the duration of the Order (up to six months).²³ Whether or not the authorised treatments are administered, and the frequency of administration are clinical decisions. If an Order expires or the authorised number of treatments are used, and the person's treating psychiatrist is of the view that further ECT is needed (and the person still lacks capacity or is under 18 years old) a further application can be made to the Tribunal.

While slightly different provisions apply in each of the case types referred to above, when deciding on any application for an ECT Order the Tribunal is required to focus on two key questions:

- whether the person has capacity to provide informed consent to ECT; and
- whether there is no less restrictive way for the person to be treated.

5.1 Capacity to provide informed consent

The Act sets down a rebuttable presumption that a person has capacity to give informed consent.²⁴ Section 68 sets out the meaning of capacity to give informed consent, including four elements or domains, namely that a person has capacity to give informed consent if they:

- understand the information they are given that is relevant to the decision they are making;
- are able to remember the information that is relevant to the decision;
- are able to use or weigh information that is relevant to the decision; and
- are able to communicate the decision by speech, gestures or any other means.

The Act also sets down guiding principles concerning capacity and capacity assessments:²⁵

- a person's capacity to give informed consent is specific to the decision that the person is to make;
- a person's capacity to give informed consent may change over time;
- it should not be assumed that a person does not have the capacity to give informed consent based only on their age, appearance, condition or an aspect of their behaviour;
- a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered unwise; and
- when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately.

¹⁹ Section 93. The provisions of the Act concerning ECT for adult, compulsory patients has been the subject of recent, detailed consideration by the Supreme Court in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564.

²⁰ Section 94A.

²¹ Section 94.

²² Section 95.

²³ Sections 91 and 97.

²⁴ Section 70.

²⁵ Section 68(2).

5.2 Least restrictive treatment

In determining whether there is no less restrictive way for a person to be treated, the Tribunal must, to the extent that it is reasonable in the circumstances, have regard to various factors set out in the Act. The factors listed in the Act are not exhaustive and include both subjective and objective considerations:²⁶

- the views and preferences of the patient in relation to ECT, (including in any Advance Statement) and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the person would like to achieve;
- the views of various other persons depending on whether the person is an adult patient, a voluntary adult or a young person. Such persons include the nominated person (or medical treatment decision maker or support person in the case of voluntary adults), any guardian and carers if the Tribunal is satisfied that a decision to perform a course of ECT will directly affect the carer and the care relationship; and
- the likely consequences for the patient if ECT is not performed and any second psychiatric opinion.

²⁶ Sections 93(2), 94(3), 94A(2), 96(3).

PART B: RESPONSE TO QUESTIONS

1. What makes it hard for people to experience good mental health and what can be done to improve this (question 4)?

1.1 There are a range of mental health services but there is not a coherent mental health system

Whether there is in fact a mental health 'system' as that concept would generally be understood needs to be tested. Whilst there is an overarching framework and Mental Health Plan, clinical service delivery is by discrete Health Services that have different approaches and do not appear to communicate effectively, giving rise to fragmentation and a lack of coherence. This lack of coherence is replicated internally. It is the Tribunal's observation that within the same service different arms or branches can operate in relative isolation from each other.

It is because of this fragmentation that the Tribunal believes that rather than initially focusing on the existing design of services, the Royal Commission's inquiries should focus on what consumers, carers and clinicians describe as the treatments and supports needed at any or various points of the course of a mental illness. This enables the gap between what exists and what is required to be defined more comprehensively, and then responses or solutions can be most effective and creative. Such an approach invites and makes room for a re-imagining of the entire service mix and structures, and recognises solutions are unlikely to only be about increasing the quantum of available services, but also the type of supports that are available. In other words, not just doing more, but also doing things differently.

1.1.1 Internal silos

Consumers and carers are entitled to expect that when responsibility for a person's care is shifting between teams or parts of a service there will be collaboration and information sharing to maximise continuity of care. Service cohesion becomes especially important where transitions are critical to reducing and minimising any restrictive aspects of treatment.

1.1.1(a) Collaboration between inpatient and community treating teams

The Tribunal does observe thorough and effective collaboration between a consumer's community-based treating team, and the treating team who has responsibility for their care when a deterioration in their mental health means they require an admission to hospital. Some positive examples seem to be attributable to the approach of individual clinicians. The Tribunal is also aware of comprehensive service design reforms that some services have endeavoured to implement that are intended to 'dismantle' the divisions between inpatient and community treatment, but with varying levels of success. Jess is an example of very positive practice.

'Jess'

The Tribunal's hearing was conducted 10 days after Jess was discharged from hospital. She had a 20-day admission following a relapse of her mental illness. Prior to the admission she had not been engaging with her community mental health service.

During Jess's admission the community team was in regular contact with the inpatient clinicians to obtain updates and Jess's community case manager visited her in hospital before discharge. There were documented discussions between the inpatient and community teams prior to discharge. These interactions provided information for the community team which allowed them to respond to Jess's circumstances and preferences. Jess met with her community psychiatrist two days after discharge where they discussed her medication, side effects, her rights, supports she needed and her future aims.

However, a 'joined up' approach to service delivery is often absent. Even where a consumer has an extended period of engagement with a service, when admitted to an inpatient unit it can sometimes appear as if they arrive as an unknown person from a far-off place. This can impede effective treatment and make the experience of care frustrating for consumers and carers (including, amongst other things, creating yet another occasion on which an often-told history

needs to be repeated). The dislocation can also be replicated following a person's discharge from hospital if there is not an effective transfer back to their community treating team.

'Greg'

Greg, who is in his twenties, was admitted to hospital as a voluntary patient following a relapse of his bipolar affective disorder. Greg, his partner and parents had worked extensively with his community team on a voluntary basis for three years prior to this admission. Greg had an Advance Statement stating that his preference for first line treatment following a relapse was ECT. Greg had provided informed consent to ECT in the past and his views were well known to his community-based treating team. At the time of his admission to hospital, Greg's family alerted the inpatient treating team to Greg's preference for ECT, as outlined in his Advance Statement, and his previous successful treatment with ECT.

However, from Greg's family's perspective these plans were ignored. The inpatient treating team did not follow up with the community-based treating team who knew about Greg's history and his plans to deal with future relapses. As a consequence, they did not administer ECT when Greg was admitted, at which time he could have provided informed consent himself. Instead, they waited nearly ten days before determining that his mental health had deteriorated to the extent that he no longer had capacity to provide informed consent. At this point they placed him on an Inpatient Temporary Treatment Order and made an urgent application to the Mental Health Tribunal for compulsory ECT.

1.1.1(b) Moving between different levels of care

The treatment and support provided to individuals with a severe mental illness can involve very high levels of restriction (this is addressed in more detail below at 1.4). Accordingly, it is vital that services operate in such a way that there is a clear step-down pathway to less restrictive treatment. While this is reflected in service design (i.e. it appears to be the case 'on-paper') it is not always so in actual service delivery.

'Ali'

Ali, in his mid-forties, has been in hospital for three consecutive years – initially six months in an acute inpatient unit and then in a Secure Extended Care Unit (SECU) for two and a half years. Ali has limited English, no family and very little support in Australia. Despite treatment with medication he experiences ongoing symptoms of his mental illness. He also has a number of physical health problems. Ali does not believe he has any problems with his mental or physical health but passively accepts medication.

Initially, the plan was that Ali would stay in the SECU unit for six months to stabilise his mental state, monitor adherence to medication, minimise the opportunity for illicit drug use and assess his independent living skills and any risks. However, he has been there for two-and-a-half years due to the lack of any 'step-down' options. Ali is frustrated about his protracted hospital admission and has asked on numerous occasions to be discharged and to be allowed to return to his home country.

In the hearing, the SECU treating team acknowledged to the Tribunal that there was nothing further to be gained by Ali remaining in SECU. While he had ongoing symptoms he could go about his daily routine, including leave from the SECU without issues. In short, they said Ali had reached his baseline mental state and was unlikely to improve any further by staying in the restrictive inpatient environment of the SECU.

Instead, the treating team told the Tribunal that Ali needs a gradual transition to appropriate supervised and supported accommodation in the community. They have been exploring step-down services with Ali's guardian and have made referrals to a number of services that could be the next steps in Ali's treatment including a Community Care Unit (CCU) and Supported Residential Service. However, none of the services are willing to accept Ali. The CCU said he did not meet their admission criteria. Another service rejected Ali because he does not have an intellectual disability. This raises a question about the transparency of these admission criteria, for if they are clear why was Ali even referred? At the moment there appears to be nowhere for Ali to go.

1.1.2 External silos

1.1.2(a) *Lack of collaboration in relation to complex consumers*

The Tribunal's concerns regarding complex consumers are covered in more detail below (at 1.4). Regarding the notion of silos between the independent services that comprise the current system, complex consumers illustrate how impenetrable those barriers can be. The Tribunal would go so far as to say that the intersection of these silos, with the severe resource shortfalls that services have to manage, means that on occasion services will proactively avoid co-operation, especially in relation to complex consumers where it can sometimes appear that the imperative is to avoid being the service that takes on responsibility for a person's care and support.

'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 that 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 in order to be 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 as such did not meet their admission criteria.

1.1.2(b) *'Isolation' of forensic mental health services*

'Kate'

Kate, a woman in her early forties, was placed on a STO because her long-standing mental illness had reached a level of acuity that needed more assertive treatment than could be provided while she was in the general prison population. Kate agrees she has a mental illness and accepts treatment.

At the time of the hearing, Kate's underlying prison sentence was nearing its end. For this reason, rather than the focus being on providing immediate treatment to enable her to go back to prison, Kate's treating team was working with her on a plan to support her transition from intensive inpatient support to intensive support and treatment in the community. The goal of Kate and her treating team was to prevent her from 'falling through the cracks' when she finished her prison sentence so as to maintain her mental health and address a potential underlying cause of re-offending.

The Tribunal acknowledges that it only interacts with a relatively small aspect of forensic mental health service delivery but based on that experience the positive case study of 'Kate' is rare. Regarding security patients (i.e. prisoners or remandees on an STO) the Tribunal observes a constant state of crisis management that other organisations and individuals making submissions will undoubtedly explain in far more detail.

Tribunal hearings for security patients provide a sense of how severely unwell a person needs to be before they are transferred to Thomas Embling Hospital, and then the very short length of stay that is usually possible when they are transferred. Ideally many more individuals on an STO should have a treatment plan similar to Kate's, whose treatment while in custody is being used to lay the groundwork for a planned transition to an area mental health service (AMHS), and continuity of care in the community. This would not only promote the mental health principles, but also have the potential to advance effective reintegration of offenders in the community at the end of their sentence. Instead treatment for security patients is often unable to aim for anything more than a reduction in the acuity of symptoms, and a hope that the person will continue with treatment in prison, or as it may be summarised in Tribunal hearings, 'administering one more long acting injection before [the patient] goes back to prison'.

Even where efforts are made to develop longitudinal treatment plans for security patients, the implementation of these plans can, in the Tribunal's view, be hampered by a reluctance on the part of the relevant AMHS to fully collaborate on the transfer of a patient's care from the forensic system. One potential consequence of this is that former security patients can continue to be detained and treated at Thomas Embling Hospital as a compulsory patient on an ITO, in some cases for prolonged periods of time.

The Tribunal accepts that the circumstances of a number of these individuals are complex, require very careful planning and that progress will at times be slow. However, similar to the point made above regarding complex consumers, there can at times appear to be an active resistance to collaboration. This can transform forensic mental health from being a highly specialised but still integrated component of mental health service provision to an isolated branch of service delivery, and as a consequence of this an individual patient's progress can stall. Risk will often be cited as the barrier to progress in such cases, and the Tribunal recognises that risk does need to be carefully managed. However, from the Tribunal's observations:

1. A near exclusive focus on risk becomes a barrier to any meaningful collaboration, i.e. rather than being identified as a significant aspect of treatment planning that needs to be a focus of collaboration, risk becomes a justification for not engaging in collaborative treatment planning.
2. It is a symptom of a stretched and fragmented service system that shared responsibility for and responses to risk can seem to be beyond reach. Rather than responsibility for risk management being viewed collectively, and therefore shared by what should be the complementary components of a mental health system, it sits solely on the shoulders of the service or treating team that has direct responsibility for a person's treatment and support. (Further issues related to risk and risk management are covered below at 3.1.2 and 3.1.3.)

1.2 The impacts of limited resources / capacity

Undoubtedly, many of the submissions to the Royal Commission will address the significant gap between the demand for and available supply of mental health services. The significance of this issue might seem to give rise to a paradox regarding the Tribunal's perspective or submission. The functions of the Tribunal are such that it only comes into contact with people who are actually receiving mental health services, but often would prefer not to. Despite this, the Tribunal does observe a range of consequences arising from under-resourcing and stretched capacity. In particular the Tribunal is concerned that resourcing issues distort the intended operation of the Act – this is addressed in detail below (at 3.1.2). The Tribunal is also of the view that limited resources and capacity impede the realisation of the principles of the Act and restrict the breadth of services available to consumers.

1.2.1 Short-lived therapeutic relationships – an impediment to realising the principles of the Act

The relevance of the mental health principles is global, i.e. they are not confined to compulsory treatment rather they articulate objectives and obligations that should guide the delivery of treatment and support to all consumers and carers. Resourcing issues cannot fully absolve a failure to adhere to the principles of the Act, but it would be both unfair and unrealistic not to acknowledge that the scarcity of resources is a significant impediment to mental health services being able to fully engage with, and operate in a manner, that promotes the realisation of those principles.

A phenomenon observed by the Tribunal that is partly a consequence of limited resources and capacity, is the prevalence of relatively short relationships between consumers and the members of their treating team. It would be reasonable to expect that when a person has been a compulsory patient for any length of time there would have been the opportunity for them to get to know the members of their treating team and begin to develop a therapeutic relationship. This is not always the case. The rotation of a significant number of medical staff at regular intervals (in accordance with training programs) builds in a structural impediment to longitudinal

relationships. This is over and above changes associated with general staff movements and changes made to arrangements for treatment and care on either an individual or broader basis.²⁷

A level of longevity and continuity in the members of a person's treating team is vital to the quality of care provided, and to maximising the likelihood that a person's experience of treatment is one that reflects the mental health principles. Consumers and clinicians need to know each other and build a level of trust if:

- treatment is to promote recovery and community participation;²⁸
- there is to be supported decision making;²⁹
- dignity of risk is to be afforded to consumers;³⁰
- holistic care and support are to be provided;³¹ and
- carers are to be meaningfully involved in treatment.³²

What can be achieved when a consumer and his or her treating team get to know each other over time is demonstrated by the case of Shane.

‘Shane’

Shane, in his early forties, has a long and complex history of mental ill health and compulsory treatment and needs immediate treatment to prevent serious deterioration in his mental health as well as serious harm to himself and others. Shane also has a history of substance use and homelessness but now has permanent accommodation that provides tailored support services for people with complex needs.

Shane often disengages from treatment and when this happens his mental health deteriorates rapidly. For this reason, the treating team administers treatment via depot (long-acting injection). Shane dislikes receiving this form of treatment and administration of it has been a long-standing source of conflict between Shane and his previous treating teams. The end result has often been complete disengagement.

In the last six months Shane's treating team has negotiated a different approach to the arrangements for his treatment. Now Shane has one clinician who is responsible for administering his depot medication and a separate clinician who has nothing to do with medication and focuses solely on Shane's broader goals and support needs.

This approach is working really well; Shane maintains a distinction between his two treating clinicians and has developed what (in relative terms) is a long-standing therapeutic relationship with the key clinician focussing on his support needs that has the potential to continue. This, coupled with his stable supported accommodation, means that Shane has started focussing on his recovery goals including engaging in activities that are meaningful to him. To this end his key clinician is helping him with an NDIS application and they have started discussing the possibility of vocational training.

1.2.2 Medicalised model of treatment and service delivery

Despite the Act clearly encompassing and promoting a bio-psychosocial conceptualisation of mental health and responses to mental illness, Victoria's mental health services are frequently criticised for being heavily dominated by a medical model of treatment and service delivery. From the Tribunal's perspective while part of the explanation for this is cultural, it is also due in large part to the under-resourcing of services vis-à-vis levels of demand.

Psychosocial interventions take time and require access to multi-disciplinary team members. However, caseloads are relentlessly crushing, restricting the amount of time that can be allocated to individual consumers; while the availability of some supports such as psychological interventions often appears severely limited. This has the frequent effect of reducing interactions between consumers, carers and treating teams to brief and repetitive discussions about

²⁷ The Tribunal observes this directly in hearings where the representative/s of the treating team have only recently met, or may never have met the patient. In April-May 2019 just under 5% of hearings had to be conducted where the patient had not met one or more of the members of their treating team.

²⁸ Section 11(1)(b).

²⁹ Section 11(1)(c).

³⁰ Section 11(1)(d).

³¹ Section 11(1)(f) and (g).

³² Section 11(1)(k) and (l).

medication; and because this is often the most contentious aspect of treatment, those interactions can also be conflictual rather than future or recovery focused.

In Tribunal hearings some consumers describe their experience of care as being constantly asked whether they want to harm themselves or someone else; whether they have been seeing things or hearing voices; and then being administered an injection. Some do not want any further contact with mental health services, but a number speak of wanting additional and different supports. Over the period April-May 2019, of those patients who attended their hearing 11% spoke of the need for additional supports to what they were being provided.

Submissions by or on behalf of consumers, carers and clinicians will address in far more detail the specific services that need to be available in the future.

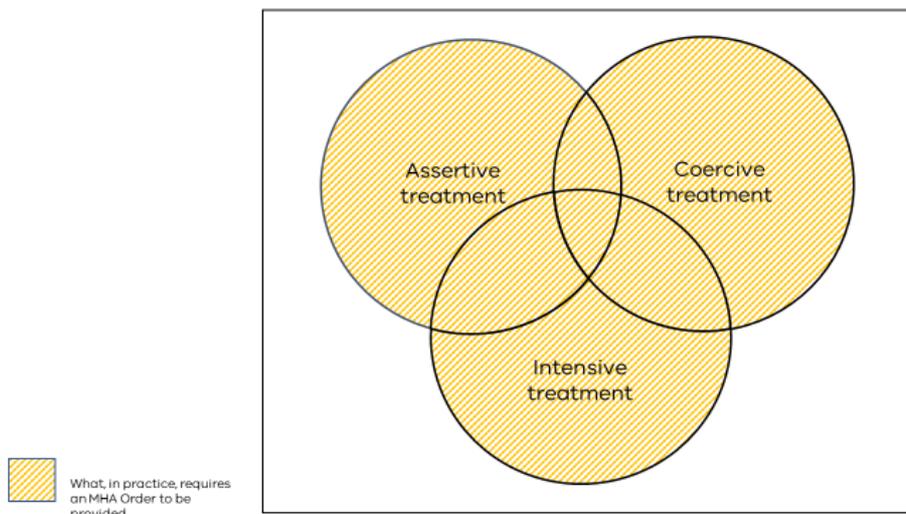
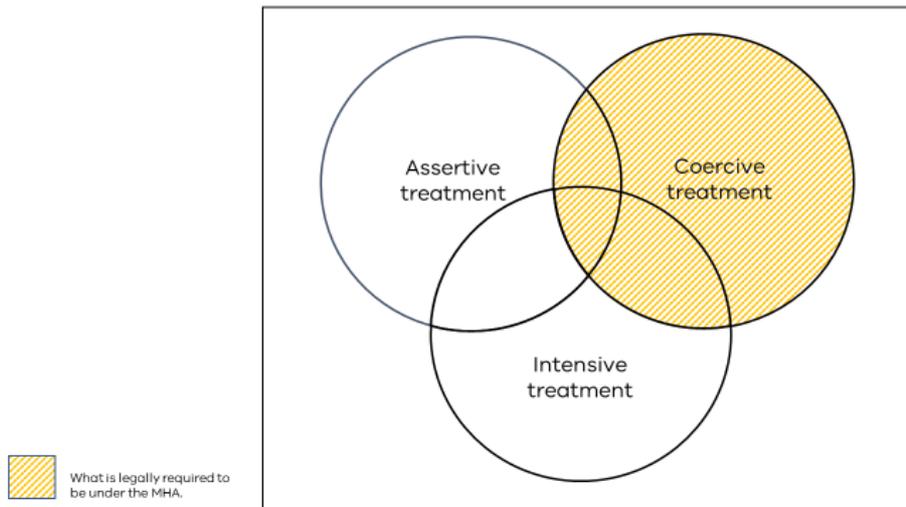
1.2.3 Inequality of access

A further distortion of service delivery and/or availability arising from the current gap between capacity and demand observed by the Tribunal is the inequality of access to services across compulsory patients and voluntary consumers. The Tribunal is not saying this is universal but based on issues frequently discussed in hearings it appears widespread.

Every report for every hearing conducted by the Tribunal concerning a TO requires the person's treating team to address the question *Describe the changes or strategies that need to occur in order for the patient to be treated less restrictively* – in other words what is the pathway to voluntary treatment? In the vast majority of cases the response is one-dimensional in that the onus is placed entirely on the compulsory patient to effectively do exactly as they are advised, at which point they may become a voluntary consumer.

Alongside this, where a TO hearing concerns a person who has received voluntary treatment in the past the Tribunal will explore what was different at that time, and what changed or led to a breakdown in the voluntary engagement between the person and their treating team. This line of inquiry will identify a wide range of matters, but a frequently described scenario will be that "John stopped attending appointments and because he was voluntary we closed his file". Related to this is the less common, but not infrequent hearings in which compulsory patients ask for an Order to remain in place because they need the more structured support it facilitates. Family and support people will often support the making of Orders for similar reasons (see below 2.2).

These scenarios all demonstrate an impoverished conceptualisation of voluntary treatment, as well as a lack of appreciation that provided treatment is not coercive it can be intensive and/or assertive and still voluntary. Voluntary treatment based on supported-decision making and respect for autonomy should not be confined to 'patients following directions', it can and should encompass periods of tension and particular sources of disagreement. How these tensions and disagreements are managed will be situation specific and might include tolerating additional risk, providing more intensive support or engaging more assertively. Neither intensive nor assertive support should be conflated with compulsory treatment. The situation and its consequences can be portrayed diagrammatically:



Compulsory status under the Act should only be about defining the legal relationship between a patient and her or his treating team at a point in time. TOs, or their absence, are not intended to determine the scope or elements of care and support provided to individual consumers. What is provided should be determined by the needs of the individual, and there should be equality of access across voluntary and compulsory patients. Restricted autonomy should not be a hidden cost of attaining access to services, and voluntary engagement should not limit the availability of intensive, even assertive support. However, in a system that is being constantly challenged to meet increasing demand without adequate resources these hidden costs and perverse incentives are real. (The related issue of how using the Act as a resource allocation tool impacts on the response to risk is examined below at 3.1.2.)

1.3 Lack of integrated supports and/or integration with equally stretched and limited support services.

1.3.1 Housing

Access to stable housing is essential to good mental health, it can also be a critical consideration that impacts upon the decision made by the Tribunal in individual cases. Whenever the Tribunal makes a TO it must also determine whether it will commence operation as an ITO or a CTO. The Tribunal can only make an ITO if it is satisfied that the person's treatment cannot occur in the

community,³³ this requires the Tribunal to consider a person's accommodation. In some cases the Tribunal will make an ITO where, if appropriate housing was available, a CTO would have been made. In other words, lack of access to housing can mean individuals are subject to more restrictive mental health treatment. Where this lack of access is prolonged, those restrictions can begin to become arbitrary and contrary to the Charter. During April-May 2019 the Tribunal identified accommodation as a critical consideration in 6% of hearings.

It is important to clarify that the connection is not linear – i.e. a lack of suitable accommodation does not mean a person will automatically be made subject to an ITO. In their understandable wish to move on from an inpatient setting some consumers will favour housing options that are transient and to varying degrees unsafe. The question for the Tribunal is whether, considering the nature of a person's illness, the immediate treatment they need, why it is needed, their level of recovery and available supports, their proposed accommodation will mean that their overall situation in the community will be one in which they are able to be treated? The answer to this question is not static and unsatisfactory accommodation may in effect become less intolerable over time where the alternative risks becoming indefinite detention.

The Tribunal will seek to manage these tensions in different ways depending on the circumstances of each case. Where there is evidence of active discharge planning and all reasonable efforts being made to locate suitable accommodation for a person who is currently an inpatient but does not have a confirmed discharge destination, the Tribunal may decide to make an ITO the duration of which will be the expected period of compulsory treatment (up to the maximum of six months). In such cases, the Tribunal will encourage continuing efforts to locate suitable accommodation, and remind parties the ITO can be varied to a CTO by the treating psychiatrist as soon as treatment can occur in the community. The patient will also be reminded of their right to make an application for revocation at any time, to bring the matter back before the Tribunal. In those matters where it appears efforts have stalled a relatively short ITO may be made – the expectation being that the treating psychiatrist will apply for a further Order which brings the matter back before the Tribunal, so it can monitor progress.

The critical importance of housing is evident in a number of the case studies in this submission including 'Jenny' whose circumstances also highlight the efforts of specialist homeless outreach teams in their work to support particularly vulnerable and marginalised individuals.

'Jenny'

Jenny is in her thirties. In addition to having a mental illness Jenny has an acquired brain injury and uses a variety of substances. She experiences homelessness and couch surfs between friends' residences. She has a chaotic lifestyle and is treated and supported by a Homeless Outreach Psychiatric Service (HOPS). Jenny has had over 30 hospital admissions. She has frequent contact with emergency services, her physical health is compromised and she is vulnerable to exploitation.

The last 18 months have seen the longest duration of consistent community treatment in Jenny's recent history. This period of relative stability has been facilitated by a CTO which has enabled regular contact with Jenny as well as consistent administration of her prescribed psychotropic depot injection by the HOPS team. Jenny was previously often lost to follow-up until she came to the attention of emergency services.

Jenny does not have stable accommodation and is vulnerable to exploitation. She has been evicted from housing previously and at the time of the last hearing it was unclear what housing options remained. Longer term, given their understanding of how Jenny would be likely to react, her HOPS team were not proposing restrictive inpatient care such as a SECU placement. The goal they wanted to work on with Jenny was to better manage her symptoms so as to reduce her erratic behaviour so that she might be accepted into and supported to remain at a Supported Residential Service.

³³ Section 55(3).

1.3.2 Alcohol and Other Drug Treatment Services

A person cannot be considered to have a mental illness – and therefore placed on an Order under the Act – based solely on the fact they use drugs or consume alcohol.³⁴ However, many individuals who are on Orders will have complex and significant issues relating to drugs and alcohol. For a small group of people there can be legal complexity where their interaction with mental health services, and the episode that gave rise to them being placed on an Order, was a drug-induced psychosis and there is uncertainty regarding whether there is a distinct mental illness. The Act ameliorates this complexity somewhat, by allowing the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol use from being regarded as an indicator that a person has a mental illness.³⁵

Given engagement with Alcohol and other Drug treatment services (AOD services) must be voluntary and the Act does require distinctions to be made between drug use and mental illness, the interplay of substance use and mental health will potentially always entail a degree of complexity. However, the Tribunal does observe a degree of compartmentalising that is unnecessary and unhelpful. Just as the presenting issues will be intertwined so too the support response should be integrated. This is a distinct issue to the question of whether AOD and mental health services should be organisationally or structurally integrated. Rather it is about however those services are organised, simplicity of access and collaboration should characterise the provision of service to individuals. Consumers should not be compartmentalised, especially on the basis of needs or issues that are inherently intertwined.

‘Alan’

Alan is in his early forties, in addition to having a mental illness he has a long standing and ongoing history of using illicit substances including stimulants, methamphetamine, opioids, and cannabis; consumption of alcohol is also an issue for Alan. In the past Alan has been in contact with the criminal justice system and has been to jail once. At the time of the hearing Alan was on a CTO and his treating team were seeking a further CTO to allow time to stabilise and monitor his mental state with the aim of avoiding a more serious relapse of his mental illness and high risk of harm or offending.

Only Alan’s case manager attended the hearing. The Tribunal heard it was difficult to support Alan’s adherence to medication although the CTO enabled the treating team to administer his depot medication regularly and maintain some contact with him. Alan’s case manager told the Tribunal he was under considerable pressure to ‘close the case’ and not pursue an application for a further TO because Alan is a ‘drug case.’ The case manager wanted to persist, he acknowledged that even with the TO the situation was less than optimal, but it could be worse. Alan had also expressed some interest in broader psycho-social supports the case manager had suggested.

1.3.3 National Disability Insurance Scheme

As the roll-out of the National Disability Insurance Scheme (NDIS) progresses, and despite the ongoing questions and concerns about how the scheme responds to psychosocial disabilities, the Tribunal has observed a very active response on the part of mental health services in terms of their efforts to assist consumers and their support people with initiating and pursuing NDIS applications. This needs to be an ongoing priority and in many cases the results appear to be positive.

³⁴ Section 4(2)(l).

³⁵ Section 4(3).

‘Stacey’ and ‘Gary’

Stacey has experienced a regular pattern of relapse of her mental illness, followed by eviction from a series of supported residential services. This has usually been followed by admission to an acute mental health inpatient unit and then discharge to another supported residential service. Last year Stacey’s mother applied for an NDIS package for Stacey which has allowed her to secure a private, rented flat and to receive four hours of support a day to help her organise her flat, attend to shopping, appointments and assist her with community interaction. At the time of the Tribunal hearing, Stacey had been successfully living in her new flat for approximately four months and finally has the prospect of stable accommodation.

Gary also recently had an NDIS package approved after his treating team made an application on his behalf. Gary now has an NDIS coordinator and receives four hours of assistance a week. Gary chose not to attend his Tribunal hearing, but asked and authorised his NDIS coordinator to participate in his absence. Gary’s NDIS coordinator attended and told the Tribunal and Gary’s treating team she was getting a better understanding of Gary’s support needs, including assistance with taking medication, attending appointments and was intending to lodge an NDIS review application seeking to increase the package to provide Gary with assistance for four hours per day as part of his recovery plan.

However, the Tribunal has also observed cases where once an application has been finalised and NDIS supports have been put in place, little if any consideration has been given to the effective integration of NDIS supports and the treatment and support being provided by mental health services. This may be a ‘teething issue’ but every effort must be made to ensure NDIS supports and mental health care, do not become two further silos within the service network that consumers and their support people need to navigate.

‘Rebecca’

Rebecca has an NDIS package that includes funding that allows her to have ongoing and regular contact with a psychologist and two case workers. Rebecca has contact with her NDIS support workers three or four times a week. However, the treating team told the Tribunal at Rebecca’s most recent hearing that they had not contacted Rebecca’s NDIS support providers, including to discuss whether there might be less restrictive treatment options such as a shared-care arrangement with Rebecca receiving treatment as a voluntary patient. The treating team acknowledged that their main response to the introduction of NDIS supports was to minimise their contact with Rebecca and it now consisted of only monthly depot appointments. No effort had been made to collaborate with Rebecca and her NDIS supports on a new treatment and recovery plan to reflect her very different circumstances.

1.4 Inadequate responses to individuals with multiple and complex needs

It is impossible for any service system, no matter how well designed and comprehensive it is, to be able to anticipate the myriad of treatments and supports that may be required by an individual with multiple and complex needs. What a system needs to be equipped to do is respond coherently, collaboratively and in a timely manner.

From the Tribunal’s experience and observation, responding to the needs of especially complex individuals confronts at least two key hurdles. First, the service that has responsibility for a complex consumer usually has to grapple with a lack of clear processes for bringing together the various agencies that need to be involved in developing and implementing a comprehensive support plan. Secondly, even when they can be brought together, impasses between agencies can result and presently no entity has clear authority to resolve these matters, if necessary, by directing what is going to happen. The result is that individuals can languish.

‘Sanjay’

Sanjay has multiple and complex needs. He has received treatment for schizophrenia for twenty years and has also had contact with the justice system in relation to serious offending. Sanjay has now been in a number of secure settings for many years.

A number of agencies have a role to play in Sanjay’s care and treatment. These include his current treating team, the community team of the mental health service that will eventually be his ‘receiving service’ as well as NDIS service providers.

Sanjay has regular Tribunal hearings and at each hearing the Tribunal seeks to ensure that the multiple agencies involved in his care are maintaining appropriate levels of communication. It was a positive development that at Sanjay’s last hearing his current treating team confirmed his potential receiving service had agreed to participate in regular discussions. That the current treating team described this as a ‘break through’ indicates how difficult it had been to secure even this basic level of engagement.

The Tribunal sought specific confirmation regarding which entity regarded it as their responsibility to ensure there was ongoing collaboration between clinical mental health services, NDIS providers and Sanjay’s advocates regarding his ongoing treatment plan. No one regarded it as their responsibility. Fortunately, Sanjay had a guardian from the Office of the Public Advocate (OPA) who volunteered to take on this role even though OPA would ordinarily be a participant in rather than coordinator of such processes.

1.4.1 Complex case management by the Tribunal

Since its inception the Tribunal has implemented assertive case management of hearings for patients who have been identified as having complex needs. The complexity may have been identified by the Tribunal in previous hearings, advocates or legal representatives representing the person, and/or the person’s treating service. While this group of patients has broadened, initially a relatively common characteristic was that they had been inpatients for an extended period (in some cases many years) and their transition to community treatment and living would necessarily involve the provision of coordinated support from several agencies.

The Tribunal is clear that its role is limited to the making of Orders. It is also committed to facilitating a hearing process that provides a forum for discussion that can maintain focus and momentum on developing a treatment plan that aims to get beyond a stalemate or ‘blockage’. Case management can include joining additional agencies as parties and requiring them to be a part of Tribunal hearings, and issuing case-specific ‘directions’ as to what information is expected for upcoming hearings.

This is a sensible use of Tribunal hearings. Furthermore, as the body being asked to make Orders that might continue an already protracted inpatient stay, the Tribunal also has a legitimate interest in, and arguably a Charter obligation to satisfy itself that these matters are being addressed. Sometimes this approach contributes to positive developments as reflected in the case study below. However, other times, because no entity can make options materialise or force collaboration, it achieves little more than ensuring lack of progress is not ignored.

‘Asha’

Asha had been an inpatient in a secure setting for a number of years and had two Tribunal hearings over a six-month period. Following the first hearing the Tribunal wrote to the parties providing a detailed outline of the information it would require for the next hearing. It also advised that it proposed to join as a party to the next hearing the service that would be responsible for treating Asha when she left the current service (the ‘receiving service’). The receiving service was also notified that it would be joined as a party to the next hearing and required to provide certain information. The Tribunal stressed that this information could be provided in collaboration with the current service.

At the later hearing, the current and receiving service presented a comprehensive treatment plan and discharge strategy that had been developed in consultation between the two services, Asha her family and VLA legal representative. The plan was creative, it was also 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 in four to six weeks.

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

1.5 Limited services for people with severe and enduring mental illness

A numerically small, but very significant group of patients that fall within the jurisdiction of the Tribunal are those with severe and enduring mental illness who receive treatment while residing in a Secure Extended Care Unit (SECU). Legally people can remain in SECU on a voluntary basis, but the majority are on ITOs, which means for those individuals there is a Tribunal hearing at least every six months. ECT applications may also be made concerning SECU patients.

By a quirk of the Act the Tribunal will sometimes receive what is effectively an application from a patient wanting to halt their proposed admission to SECU. Any compulsory patient can lodge an application for the Tribunal to review a variation to their TO transferring their care to another designated mental health service (DMHS).³⁶ Some DMHSs ‘own and operate’ their SECU and, if this is the case a patient of that DMHS cannot ask the Tribunal to review their (proposed) transfer to SECU. However, some DMHS have SECU beds or places that are located within a SECU operated by another DMHS. In these cases, because placement in SECU involves transfer to another DMHS the patient can effectively seek a review by the Tribunal.

Given this context, while some applications will be based solely on a person’s wish to not be placed in a SECU, in some cases the primary concern can be that a SECU placement involves being required to move to a location away from family and other supports. In itself this is a problematic aspect of the SECU model. Being physically located away from the area-based services that are intended to provide the support a person will need when exiting SECU (and presumably returning to their original residential area) also adds an additional layer of complexity, and potential delay, to discharge planning. It is for this reason that the Tribunal will sometimes require a patient’s SECU treating team, and a representative of the referring service to participate in hearings.

Based on our interactions with both individual patients and SECU services the Tribunal offers two observations:

1. A number of SECU patients who have Tribunal hearings have been residents of SECU for many years and given the lack of options described elsewhere in this submission, the frank reality is that some may be there for many more years. SECUs were not designed to be actual or quasi permanent residences, they are forced into fulfilling this role. No matter how well a SECU is designed and operated, for a long-stay SECU resident this means living in a locked hospital ward for many years. It is questionable whether the broader community appreciates that for some people this will be the only available option. There is a need for long-term residential services incorporating intensive models of support and care but SECU is not the answer.

³⁶ Section 66.

2. As sub-acute services SECU's are intended to be a more settled environment, within which individuals with enduring illness are provided with longitudinal treatment and support, with the aim of achieving better and prolonged reduction of highly debilitating symptoms, and regaining or developing skills for community living. This objective appears to sit uncomfortably with an increase over time in the proportion of SECU patients who for a variety of reasons, can present with aggressive behaviours. Responding to and managing for those behaviours fundamentally alters the milieu of a SECU, arguably requiring it to provide a service it was not intended to provide, at the expense of providing the environment and support for which it was established.

2. What are the needs of family members and carers and what can be done better to support them (question 6)?

2.1 Involvement in decision making

The principles of the Act include recognising, respecting and supporting the role of carers, and whenever possible, including them in decisions about assessment, treatment and recovery.³⁷ These principles are enlivened by several substantive provisions designed to involve carers at critical points relating to compulsory treatment:

- reasonable steps must be taken to notify carers of the making of an Assessment Order (AO) and any variation of an AO if the assessment will directly affect the carer and the care relationship³⁸;
- to the extent that is reasonable in the circumstances, carers views must be considered in deciding whether to make a TTO, (including whether it is for inpatient or community treatment) if making a TTO will directly affect the carer and the care relationship.³⁹ Reasonable steps must also be taken to inform carers of the making of a TTO if treatment of the person will directly affect the carer and the care relationship⁴⁰;
- carers must be notified of the variation of a TTO or TO if the variation will directly affect the carer and the care relationship⁴¹;
- for the purposes of making an application for an ECT Order, when deciding whether or not there is no less restrictive way for the person to be treated, a psychiatrist must, to the extent that is reasonable in the circumstances, consider the views of a carer, if the decision to perform ECT will directly affect the carer or the care relationship⁴²;
- carers must be notified of any Tribunal hearings concerning the person they care for,⁴³ and be given a copy of any order as soon as practicable after it is made⁴⁴; and
- if making a TO the Tribunal must, to the extent that is reasonable in the circumstances, consider the views of carers if the making of the Order will directly affect the carer or the care relationship.⁴⁵

These mechanisms were designed to address acknowledged deficits in the former Act that meant the vital role performed by family and carers was not assisted, and arguably made more difficult under the old statutory framework. It was recognised that while there was a collective as well as an individual reliance on the critical support provided by family and carers, they were often not notified of critical events and provided with the information they needed.

³⁷ Sections 11(1)(k) and (l).

³⁸ Section 32(2)(a)(iii) and section 35(4)(a)(iii).

³⁹ Section 46(2)(a)(v) and section 48(2)(a)(e).

⁴⁰ Section 50(2)(b)(i)(C).

⁴¹ Section 59(d)(iii).

⁴² Section 93(2)(e), section 94(3)(d) or section 94A(2)(d).

⁴³ Section 189(1)(g).

⁴⁴ Section 195(4) and section 96(4)(f).

⁴⁵ Section 55(2)(e).

2.1.1 Practical barriers

The Tribunal is concerned that the objective of these provisions is not being fully realised, and one of the key reasons for this is relatively mundane – accurate record keeping. To fulfil its responsibility to notify carers of upcoming hearings, and orders that are subsequently made, the Tribunal uses the demographic data stored in the state-wide Operational Data Store (ODS). The ODS includes a record of whether a person has a carer and if so, their contact details; ODS records are created and updated by Health Services. In the Tribunal’s experience the reliability of data on the ODS is far less than it should be: carers may not be recorded; carers are recorded but with incorrect contact details; carers may be linked to the wrong consumer; and former carers can remain on the record.⁴⁶

Bearing in mind that several events or decision points where carers are meant to be involved will have preceded the Tribunal’s need to notify them of a hearing, if the data we are accessing is inaccurate, carers have presumably been excluded from each of those earlier events. In other words, the intention of the legislative scheme is completely undermined. Given the complex and systemic nature of many of the issues that will be explored by the Royal Commission, accurate record keeping would seem to be a relatively quick and easy fix. The Tribunal appreciates the efforts of the department and Office of the Chief Psychiatrist (OCP) on this front, but further improvement is needed.

2.1.2 Substantive involvement

Beyond the logistics of carer participation there is the substance of how carers are involved in decision making, which can at times be complex. For instance, if a person has been placed on an AO and is being assessed for a possible TTO, their circumstances and mental health would appear to be in a state of flux and everyone’s concerns will be elevated. Added to this, longstanding or more recent, transient tensions in the relationships between consumers and carers can create challenges for carer participation in decision making at a particular point in time. Responding to these challenges is something the Tribunal has been exploring in relation to its own processes, in particular how carers can be most effectively involved in solution-focused hearings in a way that respects the autonomy of the consumer, promotes active participation by carers, and preserves ongoing relationships.⁴⁷

A very clear lesson that the Tribunal has learnt through its consultations – and which is reflected in the recent collaborative work of the OCP and Tandem⁴⁸ – is that carer participation is enabled most effectively when it is part of a ‘routine approach’ rather than event driven. In the context of carer participation in Tribunal hearings this means when carers receive notification of a Tribunal hearing it should be notifying them of something they already understood might be happening; and whether and how they might participate should be discussed and planned in advance, in collaboration with the consumer, rather than on the morning of the hearing. Yet frequently this is not the case. Similar to what was noted above regarding psychosocial interventions (see 1.2.2), this approach takes time, and when caseloads are unmanageable the Tribunal observes that a sustained and comprehensive approach to carer involvement can be one of the things that does not happen or happens less effectively.

2.1.2(a) Confidentiality v. sharing of information

A particularly complex issue that can arise is whether or not carers can provide information to a person’s treating team on a confidential basis. This is an aspect of the broader confusion surrounding the rights of a consumer to have access to clinical information, especially prior to a Tribunal hearing.

A patient who has an upcoming Tribunal hearing is entitled to access any documents held by the DMHS that are connected to the hearing at least 48 hours prior to the hearing (this is distinct from patients’ access rights under the *Freedom of Information Act 1982*). The Act does allow an authorised psychiatrist to apply to the Tribunal for an order denying access to certain documents on the basis that disclosure of the information in the relevant document may cause serious harm

⁴⁶ In late 2018 the Tribunal used ODS data to contact carers who had attended a hearing in October 2018 to invite them to complete a Tribunal Hearing Experience Survey, the data proved to be incorrect in 9% of cases.

⁴⁷ The Guide to Solution-Focused Hearings in the Mental Health Tribunal is being expanded to include materials on the effective participation of family and support people.

⁴⁸ Tandem are the peak body in Victoria for families and carers of people experiencing mental health challenges and emotional distress.

to the patient or another person.⁴⁹ This represents a significant narrowing of the equivalent provisions in the former Act which also allowed the authorised psychiatrist to seek a similar order in relation to any information that had been provided to the treating team on condition of confidentiality.⁵⁰

Over each of the past three years the Tribunal has only received an average of 53 applications for an order to deny access to documents. In a caseload of several thousand hearings per annum this would barely qualify as statistically relevant and could be interpreted as indicating that these issues are managed in a very straightforward way. This would be misleading. From the Tribunal's perspective confusion, concern and tension about access to and sharing of information within the triangular relationship between consumers, carers and treating teams is significant. Even when an application to deny access to documents has not been made, hearings will often involve fraught discussions around expectations or a wish for evidence to or discussions with the Tribunal to be confidential. The scope for confidential discussions between carers and treating teams is also constantly raised with the Tribunal in its broader educative work with all stakeholders.

Factors that contribute to this confusion include:

- lack of understanding that the former Act's allowance for any information to be provided to treating teams on condition of confidentiality is not replicated in the current Act;
- the provisions of the Act relating to this issue being deceptively complex, and despite the Tribunal publishing a suite of resources to assist consumers, carers and clinicians to understand these provisions their practical application is not straightforward; and
- low levels of awareness within services that Freedom of Information legislation co-exists with rather than over-rides rights of access information under the Act.

However, it is arguable that the primary cause of confusion is that whatever provisions happen to be included in the Act, they are an entirely inadequate starting-point for the navigation of these complex issues that are inherently relational rather than legal. The Act will most likely always need to make provision for those cases where information may need to be confidential. But to focus on the legal status of a particular document or file note of a discussion will only end in sub-optimal outcomes.

Where they exist these concerns should be addressed within a much broader exploration of who the people are that support an individual consumer, the type of support they provide, and how they can or need to be involved in treatment discussions and planning. Again, because it appears there is not always the time for such an approach to be taken in relation to carer involvement, this may not occur meaning energy and focus is instead diverted to a technical aspect of the Act which because of its inherent limitations, gives rise to outcomes that are rarely a satisfactory response to the concerns of anyone involved.

2.2 Distinct needs but compatible interests

Consumers and carers have distinct needs and expectations of mental health services. Sometimes there can be a perception that these involve nearly irreconcilable differences, but from the Tribunal's experience it warrants exploration whether the current deficiencies in service provision create or at least magnify some tensions, making them appear more intractable than they need to be.

Whether it be directly when attending hearings, or through a viewpoint being conveyed by the treating team on their behalf, carers will often support the making of a TO. Often this will be because they regard compulsory treatment as essential as the person they care for will otherwise refuse all treatment. However, in many cases it will be because carers regard a TO as a means of ensuring adequate treatment, because in the past voluntary treatment has involved less assertive and/or intensive treatment (see above 1.2.3), or a failure to respond to emerging relapses until they have become a full crisis (see below at 3.1.2). In cases such as these carers are corralled into advocating for compulsory treatment – which often means speaking against the preferences of the person they care for – when in fact what they are advocating for is effective treatment.

⁴⁹ Section 191.

⁵⁰ Section 26(8)(c) *Mental Health Act 1986*.

There will of course be differences across the perspectives of consumers and carers that are significant and in relation to which an appropriate balance needs to be struck. However, some differences, when examined more closely, may recede and agreement or common ground identified, particularly where underlying interests are (relatively) aligned.

3. Is there anything else you would like to share with the Royal Commission (question 11)?

3.1 Victoria's exceptionally high rates of compulsory treatment

As noted above, the *Mental Health Act 2014* was a catalyst for reform and in that context, it is vital to acknowledge that after five years of operation some key expectations have not been realised. This Act was intended to promote a reduction in Victoria's very high rates of compulsory treatment. This has not happened to any significant extent. While the Tribunal does not hold population data – including details of how many people are on TOs at any given time – the constant increase in our caseload and the numbers of TOs being made are both indicators Victoria's rate of compulsory treatment remains high. However, there is some evidence (although not conclusive) that the duration of episodes of compulsory treatment have been reduced.⁵¹

From the Tribunal's perspective Victoria's rate of compulsory treatment (and other restrictive interventions) should be examined by the Royal Commission; and in making this suggestion the Tribunal acknowledges that as the statutory body that makes compulsory TOs its practices and approach will need to be part of this examination and we would welcome this scrutiny. While there was significant community consultation about compulsory treatment when the Act was being developed, this did not include exploration of whether, and if so how, limited resources and the current design of the mental health service system contribute to high rates of compulsory treatment.

Further dimensions of this issue that warrant examination include firstly, whether capacity restraints have the effect of distorting the intended operation of the Act's compulsory treatment provisions, thereby limiting its effectiveness in preventing mental health crises and giving rise to irrational approaches to the principle of dignity of risk. Secondly, whether there have been gaps in the mental health discourse – especially concerning risk – that have impeded the ability of the Act to foster less restrictive responses to the needs of individuals experiencing severe mental illness.

3.1.1 Reduction in the duration of Treatment Orders and, potentially, the duration of episodes of compulsory treatment

Under the former Act an Involuntary Treatment Order provided legal authority for inpatient treatment, and also acted as a platform for a CTO when a person was able to be treated in the community. Authorised psychiatrists made Involuntary Treatment Orders and CTOs that were reviewed by the former Board. Involuntary Treatment Orders had no expiry date and existed until a person was discharged from involuntary status by their psychiatrist or the Board. CTOs could be made and renewed for a maximum of 12 months. In the Board's experience it was extremely rare to review CTOs that had been made for anything less than the full 12 months permitted under the former Act.

Since commencement of the current Act, across both CTOs and ITOs, the Tribunal has consistently set a duration significantly less than the permitted maximum. In 2017/2018, 54% of CTOs and 26% of ITOs were made with a duration that was no greater than half the maximum duration allowed, i.e. CTOs had a duration of six months or less, and ITO's three months or less.

In 2016, the Tribunal established a working group to investigate the Tribunal's approach to setting the duration of TOs. This quality assurance initiative focused on quantifying the extent to which the Tribunal sets a different duration to that requested by a patient's treating team, and the key

⁵¹The comparative research about CTO usage detailed in Light, E et al 2012, 'Community treatment orders in Australia: rates and pattern of use', *Australasian Psychiatry*, vol. 20, no. 6, p. 578-482 continues to be cited as the most comprehensive exploration of this issue. An example of more recent research into this issue is Vine, R et al 2019, 'Does legislative change affect the use and duration of compulsory treatment orders?', *Australian and New Zealand Journal of Psychiatry*, vol. 53, no. 5, p. 433-440.

factors or considerations that informed the decision. By way of a 'snapshot' the investigation found that:

- the Tribunal made TOs with a duration different to that requested by the treating team in 20% of hearings. In 92% of these matters a shorter TO was made, while a longer TO was made in 8%;
- where a shorter TO was made the most commonly cited reason was adherence to the principles of the Act, followed by presentation of the parties at the hearing. Two other less common reasons were the need for oversight by the Tribunal (i.e. making a shorter Order so that any further period of compulsory treatment would require the matter to come back to the Tribunal by way of an application for another TO); and incomplete information being available at the time of the hearing; and
- rates of attendance and participation in hearings by consumers, support persons and legal representatives was higher than the overall average in matters where a shorter TO was made.

The fact that a significant proportion of TOs are being made to run for a period of time less than the allowed statutory maximum indicates that the Act may have impacted on the duration of episodes of compulsory treatment. However, there are at least two unknown factors that require a degree of caution regarding such conclusions.

1. At this point the Tribunal has not had the capacity to conduct a follow-up exploration of the extent to which in those cases where it makes shorter TOs, compulsory treatment ends when the TO expires, or instead the person's treating psychiatrist applies for a further TO.
2. While the former Board was aware that the clear majority of CTOs under the former Act were made by authorised psychiatrists to run for 12 months, it is not aware of any data regarding how often psychiatrists discharged patients from their involuntary status prior to the CTO expiring.

3.1.2 Distorted operation of the Mental Health Act

The relative scarcity of available services leads to the Act or compulsory treatment being used as a tool to ration or determine access. This is not a function for which the Act is designed. Consequently, it results in unfair allocation of resources (see above at 1.2.3), it also distorts the effective operation of the Act and leads to irrational responses to risk. This is best illustrated by a consideration of two hypothetical consumers – 'Jack' and 'Mary'. Neither are individual case studies, nor are they 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'

Jack is a 'new patient'. He is in his early 20's and presenting with a first episode psychosis. After some initial difficulties and a readmission very 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 40's and has a long history of bipolar affective disorder. Mary has lengthy periods of stability – and is presently stable – but has also 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 concerning 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 relapse a compulsory TO is required to be able to 'act if the need arises'. When asked to elaborate on this, the rationale that is often provided is that if a person is not on a TO, intervention will not be possible until a relapse fully plays out and a serious deterioration in Jack or Mary's mental health, with the associated upheaval and distress for Jack, Mary and those who support them, has become an actuality.

But this is not what the Act requires. The relevant provisions that govern the making of AOs and TTOs do not ‘tie the hands of services’ and require them to passively observe while a person who is not already a compulsory patient descends into crisis. On the contrary, the Act positions AOs and TTOs as mechanisms to be used to **prevent** crises.⁵² While every case requires specific consideration and ultimately an Order might be made, increasingly the Tribunal is questioning the rationale advanced in support of TOs for Jack or Mary when the primary reason appears to be for it to operate as an insurance policy for the future.

There is no legal reason for such an approach leaving Jack or Mary vulnerable as voluntary patients. If at any point in the future there is evidence that demonstrates a serious deterioration in Jack or Mary’s mental health is emerging, but they are at that time refusing treatment, a compulsory intervention can be initiated with the clear purpose of stabilising their mental health and preventing further deterioration. This appears to be routinely misunderstood and/or beyond the capacity of services which in a state of constant crisis management operate in salvage rather than prevention mode.

A further pitfall of not fully appreciating the preventative focus of the Act, is that it gives rise to a paradoxical approach to the interpretation and application of the dignity of risk principle.⁵³ 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 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 achieving their potential.⁵⁴

Dignity of risk is not benign indifference – there are boundaries. The Act directs that we are 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. But what can be said is that mistakenly thinking that a crisis must have eventuated before intervening to support a person who is not presently on an Order, an approach arguably driven by scarcity of resources, potentially leads to a very illogical approach to the dignity of risk.

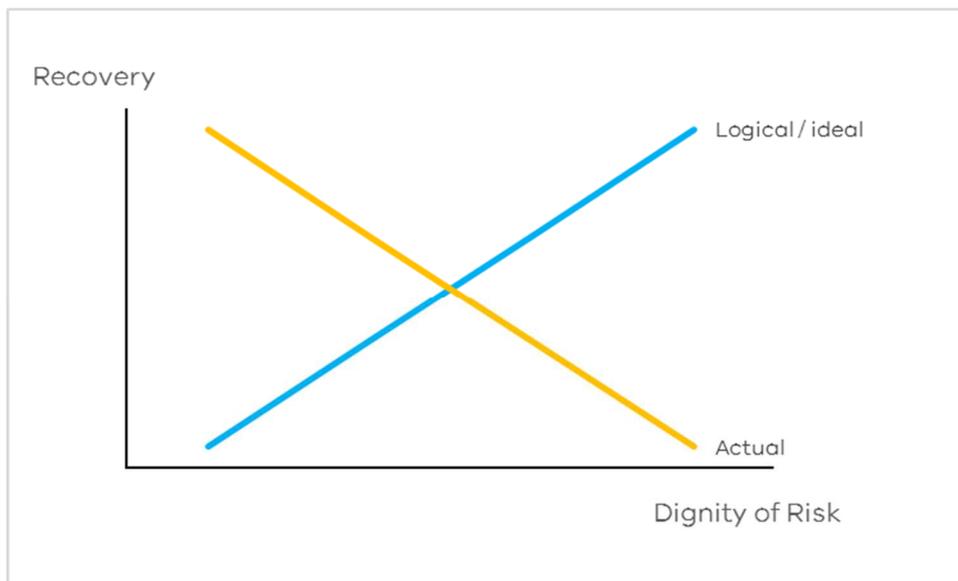
It is relatively uncontroversial to propose that a person should be afforded the liberty to take on more risk, or make riskier decisions, when their level of appreciation or understanding of the relevant risks is higher, and/or other protective factors are present – which would include a high level of rapport or engagement with their treating team. Returning to Jack and Mary, applying for or making a TO in the brief scenarios outlined arguably amounts to denying them the dignity of risk at the time 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 is not the time to afford dignity of risk, when is?

Furthermore, let’s assume that a TO is not made for either Jack or Mary but at some point in the future they begin to disengage from treatment and their mental health starts 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 take it on – when they were becoming more isolated and/or acutely symptomatic. What emerges is an approach in practice that can be the opposite of what is logical or ideal:

⁵² Sections 5(b) and 29(b).

⁵³ Section 11(1)(d).

⁵⁴ 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



One further consequence of this misinterpretation of the Act is that it is applied in such a way that it can be as if there are two different sets of criteria depending on whether they are being considered in relation to a person who is voluntary, in contrast to a person who is a compulsory patient. Put most simply, 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. Whereas 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. But this is not supported by the provisions of the Act which sets down one set of criteria that are to be applied regardless of a person's legal status at a given point in time.

3.1.3 Limited discourse regarding risk

Reflecting on the lead up to and commencement of the Act in 2014 there was arguably a significant gap, namely a balanced and frank discussion about risk, including the prevalence of retrospective blaming. Quite rightly there was significant emphasis on promoting the Act's focus on less restrictive interventions, reduced use of compulsory treatment and promoting dignity of risk. But the ability of these aims to gain traction was in hindsight always going to be limited if unaccompanied by a strategy to build genuine risk fluency, not just in mental health services but also within the broader community.

Given the frequency with which risk is referred to in various discussions, including Tribunal hearings, (by Tribunal members as much as anyone else) an observer could legitimately conclude the Act is almost singularly-focussed on risk, but this is not the case. The Act uses the term risk a total of eight times – and not one of these is in relation to the potential consequences of not making a compulsory TO. The most critical use of the term risk within the Act is to challenge all of us to be less risk averse, i.e. section 11(1)(d) which sets down the dignity of risk principle.

The relative absence of the term risk from the provisions of the Act is in stark contrast to, for example, what were proposed amendments to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA) that employed the term risk a total of 32 times, and in particular the formulation 'unacceptable risk of a person causing harm'.⁵⁵ So, while an amended CMIA would be accurately described as establishing a legal framework very much focused on risk, the Mental Health Act is something 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 and in turn persist with very high levels of compulsory treatment, when risk is approached as 'the total issue' rather than one dimension (albeit a very important dimension) of the issues to be considered when making decisions under the Act. In the Tribunal's experience 'risk' can be cited to cut off further discussion and exploration of options, and it can appear that actions will stall until an illusory and impossible risk-free option is identified.

This risk averse approach is at least partly attributable to a general lack of risk literacy within the community. Whether in a clinical or legal setting decisions made under the Act are complex.

⁵⁵ *Crimes (Mental Impairment and Unfitness to be Tried) Amendment Bill 2016*, passed the Legislative Assembly on 23 February 2017, but lapsed in the Legislative Council.

There will be those matters where the weight of information or evidence that is available overwhelmingly points to one conclusion, but more often there are equally valid considerations that pull in opposing directions, and the final decision is something about 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 a retrospective lens that presumes there was a definitively correct or incorrect answer in all cases.

No one can predict the future; and this includes the future conduct and decision making of any person who has a degree of self-agency. Not only do individual decision makers lack this predictive ability, so too 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, there appears to be poor community understanding of this, and secondly, there is a reluctance to be transparent with the community and acknowledge that not all risk can be eradicated.

Acknowledging this is not to abrogate responsibility. All decision makers must be accountable for their decisions, but that accountability should be for the rigour of their decision-making processes, and not for autonomous decisions and actions of individuals that occur after a decision has been made in accordance with sound and comprehensive processes. The case of Helen is an example.

‘Helen’

Helen was in her late 20’s and an inpatient in a secure setting, she had an extensive drug taking history dating back to her early teens, a long-standing diagnosis of a mental illness, and 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, she was also six months pregnant. Helen’s treating team were seeking an ITO. This was an entirely reasonable proposal given the level of chaos and deprivation that had characterised Helen’s living conditions prior to 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 for her.

The Tribunal made a CTO. Some months down the track in a subsequent hearing for Helen, the Tribunal found out what had happened after it made the CTO. Helen did resume her drug use prior to having her baby, and the baby had been 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. Not only would that approach require predictive powers, it also makes the erroneous assumption that the continued detention of Helen would not have a potential downside that was equally undesirable and serious. All options in mental health, even those that might appear ‘safe’ or risk-averse, on closer examination do in fact carry risks. So how should a decision be assessed? What are the questions that should be asked in a retrospective assessment of decision-making, and especially in any assessment of whether risk was properly considered? Dr Sally Wilkins proposes the following list:⁵⁶

- 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 alternate decisions identified and considered, including how they intersected with the individual’s preferences, values and long-term goals?

⁵⁶ 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.

- 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”). Something that is vital if we are going to adhere to the Act’s implicit and explicit challenge to be less risk averse.

These issues are complex but a lesson from the first five years of operation of the Act is that a broader community discussion about mental health and risk is needed if we are to successfully design, implement and then maintain a mental health service system that responds better to the needs of consumers, and is less reliant on compulsory treatment.

4. What can be done now to prepare for changes to Victoria’s mental health systems and support improvements to last (question 10)?

4.1 Developing a consistent and robust culture of service delivery

To be sustainable and capable of continued evolution in response to the changing needs and expectations of consumers and carers, the future mental health system must be underpinned by a culture of patient focussed, empathic service delivery that is consistent across its constituent parts, robust and proactively monitored. That culture can be articulated now, and steps taken to embed it so that there is a platform for the service system that emerges from the recommendations of this Royal Commission.

Limited capacity and the gap between supply and demand lies at the heart of many of the problems of the current system. But from the Tribunal’s perspective a further contributor is what is arguably a less obvious consequence of years of under-resourcing, and that is an erosion of culture. This is evidenced by many of the significant issues that are the focus of this submission. For instance, the lack of collaboration between separate parts of the current system referred to at 1.1.2. The Tribunal recognises that when resourcing is inadequate cross-service collaboration may be difficult and slow, but abandoning efforts to collaborate points to a more fundamental and profound deficit. The Tribunal observes additional symptoms of this erosion, which is occurring not through deliberate intention, but because of services being constantly stretched.

4.1.1 Different rates of patient and carer attendance at Mental Health Tribunal hearings

The Tribunal is obliged to notify patients and carers of upcoming hearings. Recently the Tribunal has implemented a range of initiatives to encourage higher rates of attendance including simplified written notices of hearing; designing a more user-friendly and accessible website; implementing periodic surveys to explore how consumers and carers experience hearings; and examining strategies to find out why people choose to not attend. Increasing attendance levels remains a constant priority of the Tribunal.

Services also play a key role in facilitating patient and carer attendance. This role can be very practical (e.g. assisting a community patient to attend the clinic for their hearing) but it is also about actively encouraging attendance by helping people prepare, reassuring them about what will happen, and encouraging them to attend and have their say. As explained earlier (see 2.1), services play an essential role in relation to carer attendance at hearings given the Tribunal relies upon the contact details of carers recorded by services to forward hearing notices.

Across the 57 services where the Tribunal conducts hearings there is enormous variation in the rates of attendance.

- For inpatient units, the highest rate of patient attendance is 88%, the lowest is 55%. Carer / support person attendance ranges from 2% to 11%.
- For community clinics the highest rate of patient attendance is 65%, while the lowest is 27%. Carer / support person attendance ranges from 1% to 16%.

- For venues where hearings are conducted for both hospital and community-based patients the highest rate of patient attendance is 76% and the lowest is 51%, while carer / support person attendance ranges from 7% to 32%.

Variations in attendance levels do need to be interpreted cautiously as there will be some venues where there are features of the patient population that contribute to different attendance rates. However, even with this caveat, the Tribunal's view is that a factor contributing to these variances is that some services have a culture that places far more importance on, and effort into encouraging their compulsory patients and their support people to be part of the process that independently evaluates whether they should continue to be on TOs.

In the Tribunal's first survey of consumers and carers experience of hearings, 36% of respondents stated no one helped them prepare for their hearing. Similarly, in a workshop exploring reasons for non-attendance at hearings that was conducted as part of the Tribunal's 2019 Consumer and Carer forum, a number of participants described a lack of support or encouragement to attend. Some participants also referred to the impact of medication not being considered by services when hearing times were being arranged, and as a consequence being unable to attend (or if they did attend being unable to participate meaningfully).

4.1.2 Engagement of services with Mental Health Tribunal hearings

By the end of its life the former Board had been completely marginalised. The legislative framework defining its review role was largely passive and there were no consequences for services not preparing for hearings, (in its final year of operation 4,000 hearings – equivalent to 40% - were adjourned or rescheduled). Several services also acknowledged there was no senior staff member who had responsibility for hearings. There have been dramatic improvements partly due to necessity, (the Tribunal's functions under the current Act are not passive and delayed hearings do have consequences) and partly due to attitudinal change. Despite this the Tribunal continues to encounter less than satisfactory engagement with its processes. This can play out in various ways.

4.1.2(a) Quality of Reports for Tribunal Hearings

Reports for hearings may be incomplete, inaccurate or out of date – sometimes by months if they are simply an old report that is being resubmitted without being revised. Reports for Tribunal hearings are often exclusively medical in that they:

- focus on diagnosis and pharmacological treatment;
- use large amounts of jargon and acronyms (a number of which are service specific and not commonly understood);
- fail to articulate a potential pathway to voluntary treatment; and
- use language that is reductive of the consumer's experience and not recovery-focused, for example symptoms of illness are recorded as factual, while experiences of side-effects are alleged, or complaints.

The Tribunal recognises the template it provides for reports is a contributing factor and it is being reviewed with the aim of reducing its length, and framing questions in such a way that they prompt a patient-focused summary of a treating team's reasons for thinking the treatment criteria are met. Ideally this could be developed jointly as part of various earlier discussions occurring between a patient and their treating team, rather than being a separate document prepared only for the Tribunal, that can be demoralising for patients and amplify differences with their treating team.

4.1.2(b) Access to Information

A further issue in relation to the reports that treating teams prepare for hearings is that under the Act they are required to provide a copy of the report to the patient at least 48 hours before the hearing. The patient is also entitled to access relevant information on their clinical file in the same time frame.⁵⁷ Given the issues at stake, on an objective measure this is not an onerous obligation. Yet access to information including reports is not always provided to patients in the timeframe set down in the Act. During April-May 2019 11% of patients did not receive a copy of their report

⁵⁷ Section 191.

in the specified timeframe, 9% of patients attending their hearing said they had not been given access to their file despite wanting to review its contents. This is more than a procedural matter it discloses a degree of asymmetry in relation to the practical application of the Act in that a clear obligation owed to a compulsory patient is treated as discretionary.⁵⁸

4.1.2(c) Hearing Attendance

Hearing attendances on the part of the treating team are also informative. For hearings conducted over the period April-May 2019, the patient's treating psychiatrist attended in 27% of hearings, their case manager / key clinician in 42%, and in all but a very small number of hearings a doctor (ranging from a senior registrar to very junior medical officer) attended. For thorough, effective and solution-focused Tribunal hearings it is essential to have representatives of the treating team who know the person and can address the medico-legal issues that need to be considered; are familiar with the broader psycho-social supports that are or can be provided; and who have both the knowledge of the person and authority to meaningfully discuss options and alternatives for a person's treatment. Often this will not be the case, which suggests a failure to understand that the Tribunal is there as an inquisitorial body to explore the circumstances of an individual patient from all angles, and consider and weigh all perspectives. This lack of understanding is most pronounced when, as does happen, the Tribunal's role is framed as 'undermining' or even 'sabotaging' treatment; and (especially in relation to ECT hearings) a decision contrary to the perspective of the treating team can be met with incredulity that the Tribunal's role is anything other than to grant the Order that is being requested.

Regarding each of the matters referred to at 4.1.2 – 4.1.2 the issue is not the Tribunal *per se*, but what this level of engagement, or lack of engagement, indicates regarding attitudes to compulsory treatment. There is an under-appreciation of the power and privilege vested in the mental health system in that it has available to it mechanisms that can compel individuals to have treatment they might otherwise refuse. The seriousness of deciding to use those mechanisms should never be underestimated. Serious engagement with the processes that provide oversight is an indivisible aspect of compulsory treatment, and demonstrates respect for individuals receiving treatment compulsorily. But this engagement can at times appear perfunctory.

4.1.3 Electroconvulsive treatment

Vesting the Tribunal with an ECT jurisdiction has drawn us further and more directly into the 'treatment space'. This has provided the Tribunal with a new perspective on some issues, including differences in approach across Health Services, that are arguably also reflective of culture. These concern ECT availability and the significant variation in the rates of urgent ECT applications across different services.

- Regarding ECT applications, the Tribunal must finalise any application for an ECT Order within five business days.⁵⁹ Applicant psychiatrists can apply for an urgent hearing if a course of ECT is needed to save the life of a patient, prevent serious damage to the health of a person, or to prevent significant pain and distress.⁶⁰ When the Act was passed it was envisaged urgent applications would be uncommon,⁶¹ but on average over the Act's five years of operation, 56% of ECT Order applications have been urgent. Furthermore, there is an enormous variation across inpatient units with the lowest rate of urgent applications being 29% and the highest 92%. The Tribunal recognises that no one reason explains this variation, but one reason is undoubtedly local culture. Some services will progress to using compulsory ECT much more cautiously than others.

⁵⁸ A logical question that arises from this is what, if anything, the Tribunal does to raise standards or compliance? This is not straightforward. At the start of a hearing the Tribunal confirms whether patients have been provided with their report, and access to their file if they wanted it. When this has not occurred, the Tribunal will consider standing-down or adjourning the hearing. However, patients will frequently express a preference to finalise rather than delay their hearing, and if this is the case the hearing will often proceed.

⁵⁹ Section 95.

⁶⁰ Section 95(2).

⁶¹ 'The government has been advised that the likely need for emergency or 'same day' ECT is extremely rare because of the nature of the treatment and the way it is administered. Accordingly provisions to allow emergency ECT without consent of the patient have not been included in the Bill. Nevertheless, it is recognised that in some cases the commencement of a course of ECT may be urgent. The tribunal will be able to expedite a hearing in response to an urgent request'. Mental Health Bill 2014, Second Reading Speech, House of Assembly, Minister Wooldridge, Thursday, 20 February 2014, p. 476.

- Two aspects of ECT availability concern the Tribunal. Firstly, most services will only administer ECT on set days of the week, most commonly Monday, Wednesday and Friday. This is problematic because requests for urgent hearings will often be at least partly motivated by the need to fit the patient within the service's ECT schedule. Urgent hearings mean patients have less time to prepare for their hearing and seek support or advice, yet it is always patients who are expected to bear these consequences – service flexibility, such as administering treatment on a Tuesday or Thursday, is an impossible alternative. The Tribunal is also concerned that not all services are equipped to offer ultra-brief ECT; and, while there has been a shift, some services are reluctant to use anything other than bi-temporal ECT.

The Tribunal's view is that approaches to ECT provide a significant glimpse into service culture. As noted above (see Part A - 5) ECT continues to be a contentious treatment. Given this, the highly varied approaches to its use, including how soon compulsory ECT might be used in a person's treatment, and the form of ECT used are especially significant. This significance becomes even more pronounced because users of public mental health services cannot choose to go to a service that has an approach in line with their individual preferences, instead they must attend the service in their geographical area. Furthermore, the legitimacy of ECT is not undermined by acknowledging it can have side-effects, most notably in relation to memory. Given this, when ECT is being administered on a compulsory basis it is difficult to reconcile the principle of patient-focused treatment and service delivery, with a resistance to commencing treatment with the form of ECT with the lowest side-effect profile unless there is a sound clinical reason, specific to the individual, for doing otherwise.

Based on five years' observation and experience the Tribunal is concerned that resourcing issues can impact inappropriately on approaches to the use of ECT, in that the need to expedite hospital discharge places time limits on the ability of treating teams to try and work with individual patient preferences. Tribunal decisions on ECT applications reflect that the law does not require ECT to be a treatment of last resort. But for individuals who lack capacity, and especially if they have concerns about ECT (expressed at the time or in the past) bed pressures and other system considerations should not be a factor in the decision to propose ECT for a consumer.

5. What can be done to attract, retain and better support the mental health workforce, including peer support workers (question 7)?

In its contribution to the consultation regarding the terms of reference for the Royal Commission the Tribunal noted that of necessity the process of the Royal Commission will require frank and often confronting truth-telling, and in that context it would be vital to keep in mind that the systemic failings of a mental health system are not typically the result of individual wrong doing, and unfair attribution of blame must be avoided. In line with this, the Tribunal has sought in this submission to highlight the examples of strong, effective practice that it observes.

Just as the Tribunal does not speak for consumers and carers nor does it speak for the mental health workforce. However, we do offer the observation that a mental health system that better meets the needs of consumers and carers will also surely be one that is a desirable, long-term workplace. This is not to conflate the interests and perspective of consumers, carers and clinicians, but to recognise those interests are not inherently incompatible and may be jointly realised. A service system with the capacity to respond to actual levels of demand will be one that is not constantly crisis driven. Engaging with more consumers based on voluntary collaboration rather than legal compulsion must be preferable to everyone. If this compatibility of interests can be identified it will foster the sense of shared purpose, collaboration and enthusiasm that will be essential to the successful implementation of the Royal Commission's eventual recommendations and identified solutions.

5.1 Occupational Health and Safety

It is important to acknowledge that there is a further issue concerning risk in mental health service provision that unavoidably impacts on the provision of support and treatment, but also raises distinct considerations. This concerns the level of interpersonal violence and abuse that is experienced by staff in clinical mental health services.

There will be a variety of other entities engaging with the Royal Commission that will explain this issue from a much broader and better-informed perspective than the Tribunal. The Tribunal's exposure to these matters is usually in the planning for potential violence and aggression in Tribunal hearings, (both universal precautions and specific strategies for a person with a history of aggressive or violent behaviour) and in a very small number of matters there can be violence and aggression in hearings. Information before the Tribunal will also outline the measures that need to be taken in some cases to provide treatment in exceptionally volatile situations, both in inpatient units and the community.

The Tribunal fully supports the right of mental health staff to a safe workplace. The Tribunal also notes that in line with the observations made above, this is not an issue in relation to which there is necessarily a tension between the rights or expectations of staff and consumers. A safe environment is everyone's right, and benefits everyone. The response to risks of violence and aggression need to be multi-faceted and adequately resourced. This is especially critical to ensuring the management of these risks does not default to a strategy of operating in siege or fortress, mode which gives rise to environments in inpatient units and community clinics that are counter-therapeutic for consumers and demoralising for staff.

6. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination (question 1)?

It makes clear sense for the community to be most fluent in relation to high-prevalence mental health conditions, and what has been achieved in relation to both awareness and understanding of depression and anxiety is remarkable. It demonstrates public awareness campaigns regarding mental health can and do work. It is now time to direct efforts towards developing the community's understanding of low-prevalence mental health conditions.

The Tribunal offers the following observations:

- Low-prevalence conditions, in particular schizophrenia, schizo-affective disorder and bipolar affective disorder are the most common diagnoses for people who receive compulsory treatment and have Tribunal hearings. Daily the Tribunal observes consumers' rejection of these diagnostic labels. Sometimes this is because the individual does not regard themselves as having any mental illness. Other times it appears to be a consequence of these being such loaded terms that carry significant stigma (borne out by the fact that some consumers will self-select a different diagnosis, usually PTSD, anxiety or depression). It is an important feature of the Act that it does not require the Tribunal to focus on diagnosis, rather the focus of the Act is on clusters of symptoms impacting on a person's thinking, mood, perception or memory. This deliberate avoidance of diagnostic terminology – language and terms that can seem bereft of hope even in treatment spaces, and are associated with ill-informed and inaccurate stereotypes – could inform at least the initial approach to developing community understanding of these conditions.
- Messaging in relation to low-prevalence conditions must reflect hope and recovery principles and do so in a nuanced way. The community must understand that recovery is defined by each individual for themselves. For some people it may be a complete remission of active symptoms, while for a host of reasons for others it will be living with an ongoing level of symptoms. In conveying the message that people do recover the community also needs to appreciate that treatment can be complex; that conditions can relapse even when being treated; and for some individuals their condition will be enduring, and their support needs high.

APPENDIX A: TREATMENT ORDER STATISTICS AND DEMOGRAPHIC DATA

Treatment Order Determinations	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
Community Treatment Orders made	2,588	48%	3,120	52%	3,423	54%	3,547	55%	3,824	56%
Inpatient Treatment Orders made	2,324	44%	2,482	42%	2,502	40%	2,580	40%	2,525	37%
Orders revoked	417	8%	358	6%	371	6%	340	5%	500	7%
Total	5,329	100%	5,960	100%	6,296	100%	6,467	100%	6,849	100%

Gender	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>Treatment Order hearings</i>										
Female	2,060	39%	2,298	39%	2,430	39%	2,477	38%	2,615	38%
Male	3,251	61%	3,661	61%	3,865	61%	3,989	62%	4,232	62%
Non-binary	0	0%	1	< 1%	1	< 1%	1	< 1%	2	< 1%
Not recorded	18	0%	0	0%	0	0%	0	0%	0	0%
Total	5,329	100%	5,960	100%	6,296	100%	6,467	100%	6,849	100%

Age	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>Treatment Order hearings</i>										
Child (< 18 years)	69	1%	78	1%	58	1%	78	1%	82	1%
Adult (18 to 64 years)	4,838	91%	5,414	91%	5,754	91%	5,851	90%	6,219	91%
Aged (> 65 years)	422	8%	468	8%	484	8%	538	8%	548	8%
Total	5,329	100%	5,960	100%	6,296	100%	6,467	100%	6,849	100%

DIAGNOSIS	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>Treatment Order hearings</i>										
Schizophrenia	2,834	53%	2,988	50%	3,257	52%	3,268	51%	3,578	52%
Schizo-Affective disorder	1,112	21%	1,545	26%	1,377	22%	1,482	23%	1,539	22%
Bipolar disorder	595	11%	603	10%	634	10%	596	9%	611	9%
Depressive disorders	117	2%	98	2%	128	2%	176	3%	149	2%
Delusional disorder	99	2%	117	2%	137	2%	135	2%	163	2%
Other	572	11%	609	10%	763	12%	810	13%	809	12%
Total	5,329	100%	5,960	100%	6,296	100%	6,467	100%	6,849	100%

APPENDIX B: SECURE TREATMENT ORDER STATISTICS AND DEMOGRAPHIC DATA

STO Determinations	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
Remain security patient	98	96%	76	97%	72	92%	77	97%	84	100%
Discharged as security patient	4	4%	2	3%	6	8%	2	3%	0	0%
Total	102	100%	78	100%	78	100%	79	100%	84	100%

Gender	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>STO hearings</i>										
Female	25	25%	17	22%	13	17%	15	19%	9	11%
Male	77	75%	61	78%	65	83%	64	81%	75	89%
Total	102	100%	78	100%	78	100%	79	100%	84	100%

Age	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>STO hearings</i>										
Adult (18 to 64 years)	102	100%	77	99%	78	100%	78	99%	84	100%
Aged (> 65 years)	0	0%	1	1%	0	0%	1	1%	0	0%
Total	102	100%	78	100%	78	100%	79	100%	84	100%

DIAGNOSIS	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>STO hearings</i>										
Schizophrenia	61	60%	40	51%	47	60%	53	67%	54	64%
Schizo-Affective disorder	17	17%	25	32%	16	21%	9	11%	13	15%
Bipolar disorder	10	10%	3	4%	1	1%	4	5%	5	6%
Other	14	14%	10	13%	14	18%	13	16%	12	14%
Total	102	100%	78	100%	78	100%	79	100%	84	100%

APPENDIX C: ECT ORDER STATISTICS AND DEMOGRAPHIC DATA

ECT Determinations	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>Compulsory adults</i>										
ECT Orders made	544	89%	612	88%	581	85%	669	89%	560	84%
Applications refused	66	11%	86	12%	100	15%	79	11%	105	16%
Total	610	100%	698	100%	681	100%	748	100%	665	100%
<i>Young people (compulsory and voluntary)</i>										
ECT Orders made	6	75%	12	100%	9	90%	4	100%	10	91%
Applications refused	2	25%	0	0%	1	10%	0	0%	1	9%
Total	8	100%	12	100%	10	100%	4	100%	11	100%
<i>Voluntary adults</i>										
ECT Orders made	-	-	-	-	-	-	9	90%	41	100%
Applications refused	-	-	-	-	-	-	1	10%	0	0%
Total	-	-	-	-	-	-	10	100%	41	100%
Total ECT hearings	618	100%	710	100%	691	100%	762	100%	717	100%

Gender	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>ECT hearings</i>										
Female	336	54%	356	50%	384	56%	404	53%	372	52%
Male	282	46%	354	50%	307	44%	358	47%	345	48%
Total	618	100%	710	100%	691	100%	762	100%	717	100%

Age	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>ECT hearings</i>										
Child (< 18 years)	3	<1%	10	1%	3	0%	1	0%	9	1%
Adult (18 to 64 years)	448	73%	483	68%	476	69%	534	70%	480	67%
Aged (> 65 years)	167	27%	217	31%	212	31%	227	30%	228	32%
Total	618	100%	710	100%	691	100%	762	100%	717	100%

DIAGNOSIS	1/7/2014 - 30/6/2015		1/7/2015 - 30/6/2016		1/7/2016 - 30/6/2017		1/7/2017 - 30/6/2018		1/6/2018 - 31/5/2019	
	Number	%								
<i>ECT hearings</i>										
Schizo-Affective disorder	170	28%	230	32%	146	21%	201	26%	191	27%
Schizophrenia	159	26%	173	24%	188	27%	194	25%	199	28%
Depressive disorders	144	23%	128	18%	163	24%	165	22%	144	20%
Bipolar disorder	96	16%	115	16%	107	15%	114	15%	102	14%
Other	49	8%	64	9%	87	13%	88	12%	81	11%
Total	618	100%	710	100%	691	100%	762	100%	718	100%