Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF MATTHEW CARROLL

I, Matthew Gerard Carroll, President of the Mental Health Tribunal (the **Tribunal**), of Level 30, 570 Bourke St, Melbourne, Victoria, say as follows:

Professional background

1 I am currently the President of the Tribunal. I have been the President of the Tribunal and its predecessor, the Mental Health Review Board, since May 2010.

2 I am a lawyer, admitted to practice in 1993. My employment history is based exclusively within a range of independent statutory authorities in the fields of anti-discrimination and human rights law, law reform and mental health.

3 As President I have overall responsibility for the operation of the Tribunal. At its core this means ensuring the Tribunal performs its statutory functions in accordance with the *Mental Health Act 2014* (the **Act)**. More broadly, the Tribunal also strives to operate in accordance with the Council of Australasian Tribunals' *Tribunal Excellence Framework*.

4 My evidence is primarily on behalf of the Tribunal. I have specified when I am expressing a personal view or observation.

QUESTIONS FOR PANEL MEMBERS

Question 1: How and why does the approach to compulsory treatment in mental healthcare differ to other areas of healthcare where greater agency is provided to individuals?

5 Mental health legislation and compulsory treatment are highly contested. The Tribunal cannot ignore this debate but as an independent, statutory decision maker it must remain impartial. The Tribunal's role is to impartially consider and apply the criteria in the Act as well as the principles underpinning the Act in order to make decisions on the matters that come before it. Within these parameters the Tribunal notes that:

- At its core, the legal framework that we presently have in Victoria is a reflection of a community view that in situations where a person may reject or be unable to consent to treatment for a mental illness and that treatment is needed to prevent serious deterioration or serious harm, the law should allow interventions to provide the support needed to prevent or reduce those risks.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

- In the second reading speech for the bill that became the current Act, the then Minister stated that stand-alone mental health legislation was the best way to protect rights and promote autonomy. The Tribunal acknowledges that there is a widely held view to the contrary – that legislation focused exclusively on mental health is a form of statutory discrimination that contributes to stigma.

- The Act also represents an attempt to balance tensions between rights and interests. It seeks to balance first-generation (libertarian) rights and second-generation rights (which include the right to a high standard of healthcare). Again, the Tribunal notes that many would argue there should not need to be a 'trade-off' between these rights. There is also the issue of balancing individual autonomy and community interests – i.e. fully autonomous decision making about treatment can potentially lead to harmful consequences for other members of the community.

Question 2: From your perspective, in what ways, if any, does compulsory treatment provide benefit to:

a. people living with mental illness, including children and young people;

b. family and carers;

c. the community;

d. diverting demand for more acute mental health services, such as admission to an acute mental health inpatient unit?

6 I think it is important to make the point that in terms of the treatment being provided, compulsory treatment should be no different than treatment available on a voluntary basis. Compulsory treatment should afford the same type of intervention and supports as voluntary treatment (and vice versa). The difference is the legal relationship between the person and their treating team. This may seem to be a statement of the obvious but in the Tribunal's experience the point can become lost. This can lead to discussions where the absence of an Order is framed as the primary or sole cause of relapses, which ignores the reality that people engaging in uninterrupted treatment – voluntary or compulsory – can and do relapse.

7 The Tribunal observes many instances where the treatment facilitated by an Order is of benefit to the person. In some circumstances, we observe a benefit that the person themselves may not recognise or see as beneficial and their different perspective must always be acknowledged. The Tribunal sees people at various points during the cycle of their mental illness, from acute ill health to a period of greater stability and recovery. The more acute the situation is, the more obvious the benefit. In some instances, interventions pursuant to an Order are nothing short of life saving. For example, a person may have

stopped eating or drinking because of their symptoms, or be engaging in self-injurious or harmful behaviour that represents a threat to their own life. In addition, and again acknowledging that views on this may differ, we see people impacted by profound levels of distress, or in a situation of near absolute social isolation or extremely high levels of dysfunction, and treatment under an Order can be somewhat of a 'circuit-breaker' and platform for recovery.

8 Further along in a person's course of illness and recovery, it's not that the benefits of treatment disappear, but the balance regarding treatment on a compulsory Order can become more complicated and contested. This may be due to a number of factors, the two most common being firstly, where a person is experiencing side-effects from the pharmaceutical component of their treatment; and secondly, the reality that prolonged periods of time on a Treatment Order and the restriction on a person's autonomy that this represents, itself becomes a source of distress.

9 In relation to benefits to families and carers, broadly, when they talk to us in Tribunal hearings, their perspective will often fall into either of two categories. In the first group are the families and carers who based on their experience of supporting the person, firmly believe that in the absence of a compulsory Treatment Order, that person will, if not immediately, then within a reasonable period, disengage from supports and treatment. Families and carers fear what they regard as the almost inevitable relapse that will result, and the crisis for both the individual and others that would ensue. In the second category are those families and carers who are concerned that in the absence of a compulsory Treatment Order, the person they care for will not be able to access the services they need, when they need them, as a voluntary patient. This means that the family members or carers are almost forced into a situation of talking against the preferences and wishes of the person they care for because, based on their experience, they have doubts that adequate treatment will be provided on a voluntary basis.

10 In relation to benefits to the community, I believe that with regard to the Act's principles which talk about bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life, the Act does reflect a genuine wish on the part of the community to try and ensure that where people need treatment and assistance, that it is available and accessible to them. However, many would say that stand-alone mental health legislation perpetuates stigma and the 'othering' of mental health, and potentially reflects a discomfort or reluctance to engage with and accept individuals with mental illness, in particular those experiencing symptoms associated with less prevalent mental health conditions.

11 Regarding the diversion of demand from acute mental health services the Tribunal's view is that the answer differs according to whether you are focused at an individual or a

systemic level. Individually, the Tribunal will frequently see in a patient's treatment history that Treatment Orders have facilitated uninterrupted treatment, and this coincides with extended periods of time when a person has not been admitted to hospital. However, at a system level, as explained at paragraph 15, the way in which the Act is currently utilised or applied within services often means that rather than using a compulsory intervention to prevent a relapse in a person's mental health (which is entirely compatible with the criteria in the Act), services will wait until a relapse has occurred and they are effectively 'mopping up' a crisis. This will often mean a more restrictive, hospital-based intervention is needed, when an earlier and intensive community-based response may have prevented this.

Question 3: Are there other alternative methods to compulsory treatment to engage people in treatment? If so:

a. what are they?

b. what factors need to be present in an individual for these methods to work?

c. what features or circumstances need to be present at a systemic level for these methods to work?

d. to what extent could these methods be replicated or used more widely in Victoria?

12 One matter that does stand out for the Tribunal, in terms of an alternative to compulsory treatment, is the need for the system to have a richer understanding of what voluntary treatment can and should be. In the clinical reports prepared for Tribunal hearings, we ask treating teams to articulate the steps to less restrictive, voluntary treatment. The most common response is essentially that a patient can be treated voluntarily when they fully comply with what they are told to do in terms of their treatment.

13 In *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (PBU's case) the Supreme Court articulated a much more sophisticated concept of less restrictive treatment and how it incorporates and promotes self-determination and supported decision making (see in particular paragraph 252). Arguably it envisages a partnership or relationship that involves negotiation and the sharing of risk. Voluntariness is not limited to the consumer dutifully following medical advice. Equally importantly, it is not about a person's treating team 'pulling back' at the slightest sign of resistance. Provided an intervention is not coercive, it can be assertive and/or intensive while still voluntary. However, the Tribunal observes it is not uncommon that for people who are not on an Order, should they miss some appointments or stop answering phone calls their file will be closed. We learn of this because what will frequently happen is that some time after that a person's file is re-

opened at the time a compulsory intervention is being implemented to manage a relapse or crisis.

14 Resourcing issues are undoubtedly a factor in this approach – a person's status under the Act becomes a tool used to decide how to allocate insufficient resources across competing demands. Resourcing issues and the degree of movement in the mental health work force also jeopardise the opportunity for consumers and their support people to build and maintain the relationships of familiarity and trust that are essential to the vision of less restrictive treatment described in PBU. If people know and trust each other there would arguably be much greater potential to work through the issues and challenges that, in the absence of such relationships, can attract coercive interventions.

Question 4: In Victoria, the Mental Health Act 2014 (Vic) states that compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or to another person.

a. Are there other factors that influence how clinicians may seek to use compulsory treatment? Please consider the impacts, if any, of resource constraints within the current mental health system.

15 This is constantly referred to as the 'risk criterion', despite being about the prevention of serious harm or serious deterioration and not using the term 'risk'. I do appreciate that this is an understandable shorthand, but it arguably limits and distorts consideration or thinking about what this criterion is about. In particular:

- This criterion is about *prevention.* The aim is to *prevent* serious harm or serious deterioration – in other words, the serious harm or deterioration doesn't need to have eventuated before making an Order. In practice, the Tribunal often hears applications for extensions to compulsory Treatment Orders in circumstances where a person's illness has stabilised, and they are open to engaging in treatment voluntarily. However, their treating team will apply to the Tribunal for a further period of compulsory treatment on the basis that they will need to act assertively and quickly if a person deteriorates in the future. The Tribunal is concerned with that approach because there is no reason that a person engaging in voluntary treatment cannot be the focus of swift intervention to prevent a relapse or deterioration. A treating team does not have to sit passively and wait for a relapse to occur before responding (including potentially making a new Assessment Order and Temporary Treatment Order). However, the Tribunal also understands that in practice, based on resourcing issues and a misunderstanding of the Act, treating teams might only act when a situation has completely deteriorated. The Tribunal has been signalling very clearly that in cases where a person is doing well and the treating team

and person can continue engagement voluntarily, we see no need for another Order to be made.

- The term risk is so loaded that if considered in isolation it arguably restricts full exploration and consideration of options. During the consultation process that informed the development of the Act there was much discussion about the need to be less risk averse in decision making about compulsory treatment. On reflection, what was missing from this was a companion discussion about developing risk fluency and challenging our blame culture. People who are being asked to make decisions that are less risk averse do not feel confident that, should something go wrong at some point in the future, they will be supported. From my observation they were also provided with little, if any, advice on how less risk averse decision making intersects with their duty of care. They are justifiably concerned that the scrutiny of their decision making will be framed as 'why did you fail to make an accurate prediction about this risk and how to prevent it?' rather than 'was your decision-making process thorough and in accordance with the law?' This lack of balance and fluency around risk intersects with the misconceived notion of the 'risk criterion', giving rise to reductive discussions about treatment in which individuals can be conceptualised as simply potential risks and deficits, rather than as also having strengths. Such discussions can also lose sight of the fact that there is no such thing as a risk-free option – compulsory treatment can help manage risk, but it carries risks of its own and doesn't eliminate risk. None of this is to suggest risk is not real and should not be discussed – it is real and must be talked about – but it should be part of, not the totality of, the discussion.

Question 5: To what extent are the existing safeguards contained in the Mental Health Act (including advance statements, nominated persons and the second

opinion scheme) as well as current non-legal advocacy and legal representation arrangements:

a. reflective of contemporary practice and evidence?

b. compatible with international conventions on human rights?

c. operating as intended?

d. currently taken up by people who use mental health services?

e. currently taken up by families and carers?

f. currently considered in practice by clinicians when determining assessment and temporary treatment orders?

g. currently considered by the Mental Health Tribunal when determining treatment orders?

16 Arguably, if the safeguards in the Act are working optimally, the Tribunal would not be directly observing or encountering them too often as they would be contributing to a reduction in the levels of compulsory treatment. In other words, the Tribunal's exposure to these mechanisms could be at least partly impacted by a 'blind spot'.

17 The processes applied in every matter heard by the Tribunal include confirming whether the person who is the subject of the hearing has an advance statement, nominated person or requested a second psychiatric opinion. In the Tribunal's experience it is relatively rare for these safeguards to have been accessed. But where a person has utilised one or more of these safeguards, each one can be extremely valuable in their hearing. Advance statements are especially valuable if in addition to expressing preferences they explain the reasons for those preferences, thereby enabling a consideration of not only the person's position but their underlying interests. If attending the hearing a nominated person can assist the person to speak, or speak for them, in response to the issues being discussed in the hearing. In the Tribunal's experience the second opinions provided through the Second Psychiatric Opinion Service not only provide an independent clinical viewpoint, they also explain how the provider of the opinion has weighed up and considered different perspectives on, or explanations for, a range of matters.

18 Legal representation for people subject to compulsory Treatment Orders who have a Tribunal hearing is an important safeguard. The Tribunal is highly supportive of increased access for legal representation for people coming before the Tribunal. We regard legal representation as a support that facilitates participation in hearings and addresses power imbalances. Increased legal representation for people having mental health tribunal hearings was a draft recommendation in the Productivity Commission's interim report of its mental health inquiry. The Tribunal made a submission in response to the draft

recommendation, endorsing it but suggesting the rationale for the recommendation should be different. Briefly, the Productivity Commission based its recommendation on evidence asserting a correlation between legal representation and hearing outcomes. The Tribunal questions this evidence and the related analysis, nonetheless recognises and endorses the valuable contribution made by legal representation in this jurisdiction. Our submission to the Productivity Commission is available on our website (at https://www.mht.vic.gov.au/news/our-submission-productivity-commission-inquiry-mental-health) or can be provided on request.

19 The Tribunal also recognises the value of the Independent Mental Health Advocacy service (**IMHA**) provided by Victoria Legal Aid. IMHA's funding arrangement means that it does not advocate for people in Tribunal hearings (although sometimes an IMHA advocate may attend the hearing as a support person). In many hearings divisions of the Tribunal will often recommend IMHA as a support or resource that a person may want to contact if they haven't done so already. This is an especially valuable referral in hearings where a consumer's most pressing concern is not necessarily their Treatment Order as such, but some aspect/s of their day-to-day treatment. Hearings can be an effective forum to define these concerns clearly and confirm a process for their future exploration. IMHA advocates then work closely with and support consumers to pursue and resolve these concerns.

Question 6: Do current independent oversight mechanisms governing the use of compulsory treatment need to be improved?

a. If so, how?

b. What is required to ensure any changes are successfully implemented?

20 I consider one of the shortcomings of the current framework under the Act is in relation to people who have been a compulsory patient for a prolonged period of time. Some of these individuals are long term inpatients in a Secure Extended Care Unit (**SECU**), some are former security patients whose sentence has ended but who are now on an Inpatient Treatment Order, while others will have been on a series of 'rolling' Community Treatment Orders. Whatever the particular circumstances these tend to be consumers with especially complex needs. Currently, the Act conceptualises each Treatment Order and therefore each Tribunal hearing as essentially a self-contained event. In most instances this approach is logical and adequate, but it does mean that the Act makes no distinction between an application and a hearing in relation to a person who has been a compulsory patient for 28 days, and someone who has been a compulsory patient for several years.

21 Based on its obligations as a public authority under the *Charter of Human Rights and Responsibilities 2006* and a 'fulsome' approach to its functions under the Act, the Tribunal

does seek to address this by way of its procedures. For instance, a tailored and more detailed report is required for any hearing concerning a person who is an inpatient in SECU. We also identify patients for whom hearings need to be intensively case managed. Case management means the focus and content of the person's next hearing is informed by 'directions' made, and issues identified at their most recent, previous hearing (although it is important to be clear these are not formal directions and are not enforceable). A broader group of participants will often be called on to give evidence and we will endeavour to have at least some continuity in the composition of the Tribunal divisions conducting successive hearings. The rigour of, and compliance with, this procedure would arguably be enhanced if the Act conceptualised hearings for long-term compulsory patients in a different way to other matters.

22 People who are effectively 'stuck', as was noted in the Tribunal's submission to the Commission (see section 1.1.2) are of particular concern. This is a cohort of patients who are subject to extremely high levels of restriction, which is not only attributable to the nature and complexity of their needs, but also because finding solutions, or less restrictive alternatives, requires collaboration and co-operation across different services. Resource constraints and the decentralised nature of the current system not only impede such collaboration, in extreme cases it appears there is a disincentive to collaborate. Presently no entity appears to have the authority to step in and end the paralysis and direct what is to happen to improve the circumstances of these individuals. There should be an entity with this authority, I hasten to clarify I am not suggesting it should be the Tribunal.

Question 7: To what extent, if any, should compulsory treatment be used in Victoria's future mental health system?

a. Why or why not should compulsory treatment be used in Victoria's future mental health system?

b. From your perspective, if compulsory treatment is to continue, which services and settings should be permitted to use compulsory treatment?

23 In accordance with my comments in paragraph 5, I will not express a view in response to this question.

Question 8: Other than legislation, what are the other ways that could be used to reduce rates of compulsory treatment use? Please consider policy, data collection and dissemination, funding and operational levers.

a. How could they be deployed in Victoria and by whom?

b. What is required to ensure the use of these levers are successfully implemented?

24 I refer to my response to question 7.

25 Briefly, I would note that the current Act was intended to foster change and reform practice. It has achieved some success, but it is uncontroversial to say it has not met the expectations that accompanied it. The Act's (almost) six years of operation demonstrate that legislative reform is going to achieve little when the system that it is seeking to regulate or change is simply not equipped, not resourced and not structured to take the principles set down in the Act and translate them into day-to-day practices.

USE OF COMPULSORY TREATMENT IN VICTORIA

Trends in relation to compulsory treatment observed by the Tribunal

26 In terms of hearings for compulsory Orders, the increase in the number of hearings and Orders made has been constant since the Tribunal commenced operation in July 2014. Hearings conducted have increased by 30 percent over that five-year period, from just over 6600 in the first year to 8600 hearings in the last financial year. The Tribunal only records a small amount of demographic data (that primarily resides in the Client Management Interface / Operational Data Store). Based on the data we do record I can confirm:

- young people have never accounted for more than one percent of Tribunal hearings.
- people over 65 years of age account for 8% of hearings each year.
- there is a gender bias in hearings in that 61-62% of hearings concern males.

27 The number of electroconvulsive treatment (**ECT**) applications being heard by the Tribunal is always scrutinised particularly closely – both internally and externally. While it hasn't been a linear progression, ECT applications did increase over the first four years of the operation of the Act (from 610 to 748). Since the decision of the Supreme Court in PBU's case there has been a decline in applications for ECT.

SAFEGUARDS

Improvements to the take up of safeguards by consumers, families and carers

28 The Tribunal would regard an increased take up of safeguards by consumers, families and carers as positive. One means of achieving this could be through education – not simply about their existence, but about the practical impact and benefits they can offer. For example, in relation to advance statements, the first question that I imagine a consumer might ask when told about advance statements is whether a treating team will be obliged to follow what is in that statement. The explanation about an advance statement's purpose, when it is not a binding directive, may appear to be abstract and discourage a person from making a statement, or to be sceptical about their value. Developing and making available case studies that demonstrate how advance statements have worked or been positive for other consumers would be invaluable.

INDEPENDENT OVERSIGHT

The impact of the Tribunal on the use of compulsory treatment in Victoria

29 There are three matters I wish to highlight on behalf of the Tribunal:

(a) Firstly, the system of oversight under the former *Mental Health Act 1986* (Vic) (the **former Act**), that was provided by the Mental Health Review Board (the **Board**) was impoverished by the time it ceased operation. Hearings under the former Act were constantly delayed and adjourned, meaning the protections set down in the Act did not match the actual experience of consumers. This could happen because the Board's functions were passive, in that Involuntary Treatment Orders kept operating even if they were not reviewed by the Board. As such, there was little motivation for mental health services to prioritise their engagement with the Board and, frankly, they did not. It was rare for any administrative or clinical manager within services to have responsibility for compliance with the former Act's provisions governing Involuntary Treatment Orders. This changed almost immediately when the current Act commenced in mid-2014. Under the current Act, hearings occur in accordance with the strict timelines set down in the Act because if they don't, Orders expire. Services now prioritise hearings and engage with the Tribunal's processes, these matters are now part of the governance of mental health services.

(b) Secondly, the duration of compulsory Treatment Orders made by the Tribunal has reduced. Under the former Act, there was no expiry date for Involuntary Treatment Orders which meant that these Orders remained in place until discharged. Psychiatrists could also make Community Treatment Orders for a period of 12 months, which from the Board's observations operated as a default

or automatic duration. Ahead of the commencement of the Act, the Tribunal was very clear in its messaging that we would take a different approach. Whilst the Act says that Inpatient Treatment Orders can last for six months and Community Treatment Orders can be made for up to 12 months, we approach these as maximum periods, not default durations. The Tribunal's decisions about the duration of compulsory Treatment Orders are based on the circumstances of an individual. A relatively stable pattern since the Tribunal's inception in 2014 is that roughly 50% of Community Treatment Orders made by the Tribunal are for a period of six months or less, and about 25% of Inpatient Treatment Orders made by the Tribunal are made for a period of three months or less. However, the Tribunal acknowledges that it remains an open question (and one currently beyond the Tribunal's capacity to research), whether this means that people are having a shorter period of compulsory treatment, or having equivalent periods of compulsory treatment on a series of shorter Orders. What the Tribunal has attempted to change is the mindset of mental health services from one of 'make an Order for the maximum amount of time possible and cancel it if it is not needed' to a view that a compulsory Treatment Order should only be made for the amount of time it appears warranted, then if the need arises consider a further Order at a later date. The Tribunal did undertake a quality assurance review in relation to this aspect of our decision making. We identified that in roughly 20 percent of matters for the period under review (an eight-week period in 2017), the Tribunal made Orders with a shorter duration than that proposed by the consumer's treating team. The reasons identified by Tribunal members for this were primarily about factoring in the implications of the mental health principles; and weighing / considering each hearing participant's perspective about what was needed. Allowing for Tribunal oversight of some cases was a further consideration.

(c) The third matter to highlight is the Tribunal's oversight of ECT when it is used in the treatment of any adult who does not have capacity to provide informed consent, or any person under 18 years of age. The former Board had no role in relation to ECT and Victoria was one of, if not the last, Australian jurisdiction where substitute decisions about ECT were made solely by clinicians without any external oversight (beyond reporting levels of usage annually to the Chief Psychiatrist). ECT is a treatment that attracts considerable attention and passionate disagreement, some advocate for its use to be prohibited, others are perplexed that it is approached differently from any other treatment. This is another matter on which the Tribunal must be entirely impartial, but it does not breach that impartiality to note the rigorous oversight the Tribunal has brought to the use of this treatment for young people and those unable to provide informed consent seems appropriate and (as at 2014) overdue, given it is such a contested treatment.

The Tribunal's application of the Act in deciding to make a compulsory treatment order

30 From the outset the Tribunal was very clear that it would not simply be the Board with a different name. In addition to having different functions under the Act, we took the step of articulating a framework of practice called 'solution-focused hearings'. In other words, as well as having different functions, we would approach those functions differently. A solution-focused approach draws on the principles of therapeutic jurisprudence and non-adversarial justice, and our specific resources (*A Guide to Solution-Focused Hearings in the Mental Health Tribunal* available on our website at: https://www.mht.vic.gov.au/guides-policies-and-procedures) are based on a comprehensive bench book written by Dr Michael King (Michael S King, 2009, *Solution-focused judging bench book,* Australasian Institute of Judicial Administration Incorporated, Melbourne (AIJA)). With Dr King and the AIJA's permission, we adapted the bench book into a resource that was tailored to the specific context of mental health tribunal hearings. This framework of practice underpins how we approach the performance of our hearings. It enables Tribunal members to facilitate hearings in a way that encourages consumers, carers, support people and treating teams to have meaningful discussions about a person's current circumstances and hopes for the future, including their preferences regarding mental health treatment. These discussions often explore the steps or progress that would mean the criteria for making a compulsory Treatment Order no longer apply. In this way, adopting a solution-focused approach helps us to embed and enliven the mental health principles in the conduct of our hearings. For example, they are an important way to involve consumers in decisions about their treatment and recovery and to support them to make or participate in those decisions. Solution-focused hearings also respect consumers' rights, dignity and autonomy but also seek to involve carers in hearings whenever possible and to recognise, respect and support the role of carers.

The Tribunal's consideration and examination of clinical decisions around compulsory treatment use

31 The Tribunal has explored this issue in some detail (and published resources as an appendix to our *Guide to Solution-Focused Hearings*) as the extent to which a Tribunal hearing can explore issues related to actual treatment is a cause of considerable confusion. In particular, the Tribunal often encounters a view on the part of treating teams that the Tribunal is not permitted to ask questions about treatment. The Tribunal understands it is not a decision maker in respect of a person's treatment and does not decide, for example, a person's medication or dose. Even when the Tribunal makes ECT Orders, we are setting up a framework around the use of ECT rather than directing how that form of treatment will be administered. However, the Tribunal regards it as

nonsensical to suggest that a decision can be made about compulsory Treatment Orders or ECT Orders without discussing the treatment that is proposed to be given pursuant to an Order, as well as alternatives if that is a live issue in a particular case. We do not consider that these matters can be separated.

32 The message we have communicated about the Tribunal's role in relation to exploring treatment is that it is one of constructive inquiry and clarification. The Tribunal wants to know and understand the full scope of treatment and supports that a person is being offered. We want to understand whether these treatments and supports match what a consumer wants and thinks would work for them. We want to understand whether there is a treatment plan and whether that plan matches the expectations of the consumer and their carers and if not, why not. These matters are of fundamental relevance to the treatment criteria, particularly whether there is a less restrictive way for the person to be treated. We ask these questions sensitively because there may be good reasons why, for instance, a treatment plan is unable to match a consumer's expectations. However, as a statutory body subject to Charter obligations, we must conduct some degree of inquiry, and this is especially so if something does not seem right or requires explanation (for example persisting with a particular antipsychotic medication despite a person experiencing significant side-effects). The purpose of this inquiry is to be constructive and we aim to do it without jeopardising therapeutic alliances. Navigating these issues is another aspect of the Tribunal's role that is enhanced by our solution-focused approach.

The receipt of information by the Tribunal at hearings in relation to compulsory treatment orders

33 For every hearing the Tribunal is provided with a report prepared by the consumer's treating team. Treating teams use a template that is provided by the Tribunal. The template includes an instruction that if there is a treatment plan for the consumer it can be attached to the report, and to the extent that the treatment plan addresses the questions in the template there is no need to answer those questions and instead the report can simply refer to relevant part of the consumer's treatment plan. Treatment plans are not routinely provided and I cannot explain why this is the case. It is rare for the Tribunal to stand-down or adjourn a matter for a plan to be provided because that delays a person's hearing and it is more expeditious to talk through treatment planning issues that need to be clarified. What is more concerning is the question of whether consumers are at any point provided with a clear treatment plan, again I cannot comment on this.

34 The former Act had a provision for treatment plans to be provided to and reviewed by the Board in every hearing. In theory this sounds like a positive feature of the former Act, but in my view this mechanism introduced a considerable amount of process for little substantive benefit. It often generated documents the primary purpose of which seemed

to be meeting this procedural requirement in the legislation, rather than documenting a process of discussion and negotiation between consumers, carers and treating teams with a focus on mapping next steps and future goals. Instead these plans often focused on what a consumer must do, and what might happen if they didn't.

The dissemination of Tribunal decisions to health services and their incorporation into policy and clinical practice

35 It is difficult for the Tribunal to comment definitively about whether our decisions are being incorporated in policy and practice, however, I note the following:

- Only 20-25% of requests for statements of reasons are made by the treating psychiatrist.
- Following on from paragraph 29(b) above, members do observe that treating teams do more frequently request a Treatment Order duration that reflects the circumstances of the individual, but I am not able to quantify this shift.
- Treating teams have tended to be far more interested in understanding the reasons for a Tribunal decision to refuse an application for an ECT Order and anecdotally it appears these matters are discussed more broadly within services.

36 For anyone who is interested in the Tribunal's approach to interpreting and applying the Act I note that a selection of de-identified statements of reasons are published on the AustLII website. In order to assist Tribunal users to search and navigate these statements of reasons, the Tribunal has a categorised/indexed list of these statements of reasons on its website that links to AustLII: https://www.mht.vic.gov.au/statements-reasons.

37 Given we do not regard statements of reasons as the most effective means of providing health services with information about our processes and decision making, over the last two years the Tribunal has been committed to providing education for all designated mental health services at least once or twice a year. We speak to clinical staff about the Tribunal's role and functions; the approach of the Tribunal to the performance of those functions; and provide education around how treating teams can most effectively prepare for and participate in hearings. We are planning to develop more resources for clinicians and making these accessible via the Tribunal's website.

The Tribunal's administrative process prior to compulsory treatment hearings

38 Ahead of a hearing, the Tribunal requires treating teams to prepare an extract of relevant materials from the consumer's clinical file. Usually that includes the most recent progress notes and any other specialist and medical documents that may be relevant. Extensive guidance on these requirements is provided in Practice Note 8 - *Access to Documents in*

Mental Health Tribunal Hearings (available on our website at: https://www.mht.vic.gov.au/rules-and-practice-notes.)

39 As noted above treating teams also prepare a report using a template provided by the Tribunal. That template was developed in 2013/14 in preparation for the commencement of the Act, in the context of the former Board's experience of often being given inadequate information for its hearings. Informed by that experience, and because the Tribunal was to be a primary decision maker with increased information needs the template is lengthy and asks numerous questions. Quite reasonably, the feedback the Tribunal receives from clinical staff is that the template report is time consuming and difficult to prepare. The feedback the Tribunal receives from our consumer and carer advisory group and other consumers is similar. They advise the template is too long and invites the preparation of a report that is difficult and demoralising to read. To put this differently, the report doesn't lay the groundwork for a solution-focused hearing as it can focus too much on the past and everything that has previously 'gone wrong'.

40 The Tribunal is working toward an entirely different approach to reports for hearings. The current working draft that will now be the subject of extensive consultation makes the consumer the primary audience and the Tribunal the secondary user of the document. The draft template is addressed to the consumer and explains what the treating team intends to tell the Tribunal at an upcoming hearing, it also encourages acknowledgement of the points of difference and issues that may be the subject of disagreement at the hearing. The template also encourages treating teams to explain how they wish to work with the consumer and the people who support them, and describe, at least in broad terms, the steps everyone can take to progress toward voluntary engagement. Difficult issues will still need to be addressed, but only as far as necessary and with a focus on the future rather than the past.

FUTURE STATE

Data collection, synthesis and publication and the reduction of compulsory treatment

41 The Tribunal has always published extensive quarterly data that gives a detailed breakdown and profile of the decisions being made under the Act. Any tribunal should do this, but the bar is particularly high in this jurisdiction given the strict privacy and confidentiality protections that apply mean mental health matters are largely excluded from public scrutiny.

42 In publishing this quarterly data, the Tribunal acknowledges we are only providing a part of the picture regarding compulsory treatment (for instance reporting on Treatment Orders made is not akin to reporting on how many people are receiving compulsory

treatment at any given time). Victoria's Mental Health Services Annual Report, prepared in accordance with section 118(2) of the Act provides extensive information and data each year. There may be a small sub-set of that data that could be published more frequently to provide a regular snapshot of the operation of the Act.

43 The Tribunal has deliberately chosen to not report any of its statistics or data broken down by health service. Such an approach does have merit as it can highlight areas of apparent positive practice as well as discrepancies that warrant exploration. However, the Tribunal does not regard itself as the appropriate entity to be doing this as the function should not simply be about publishing the information, it should also be about facilitating the reflection and discussion it is intended to foster. This would not be an appropriate role for the Tribunal.

Research and the reduction of compulsory treatment

44 Research should continue, but I note there has been considerable research over many years and during that time the use of compulsory treatment has continued to rise. The interim recommendations of the Royal Commission make it clear lived experience will be an equal and central driver in the design and delivery of contemporary mental health services. If service delivery better matches what consumers want, I believe that will have the most immediate impact on the level of compulsory treatment.

Further comments regarding compulsory treatment

45 I will simply reiterate one aspect of the Tribunal's earlier submission to the Commission. So much of the current predicament around mental health service delivery is about the consequences of resourcing and the enormous gap between available resources and levels of demand, but additional resourcing is only one part of the solution. From the Tribunal's observations resourcing constraints have led to an erosion of culture. At times, the Tribunal observes a system that does not enable its workforce to stop and ask, 'if this was me or someone I cared about, would I want this to be happening?' Because the answer would have to be no. The Tribunal has enormous respect for the members of the mental health workforce and acknowledges the complexity of their roles, and that they work in a system that does not support them to deliver support and services as they would want to. Additional resources are essential, but culture will also need to be deliberately rebuilt. The Tribunal is not preaching on this point. Just as we did when the Act commenced and we transitioned from the Board to the Tribunal, we will need to change and adapt to meet the expectations of consumers and carers in the future mental health system.

Attached to this statement and marked 'MC-1' is a copy of my curriculum vitae.

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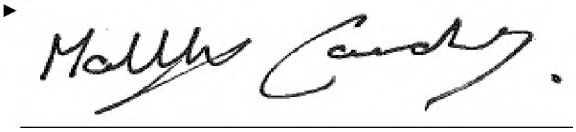

print name Matthew Carroll

date 27 April 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT MC-1

This is the attachment marked 'MC-1' referred to in the witness statement of Matthew Carroll dated 2 April 2020.

CURRICULUM VITAE

MATTHEW GERARD CARROLL

QUALIFICATIONS

1990:	Bachelor of Economics (Accounting and Finance) - Monash University
1992:	Bachelor of Laws - Monash University
1993:	Admitted to practice as a Barrister and Solicitor of the Supreme Court of Victoria

EMPLOYMENT

Current: **Victorian Mental Health Tribunal**

President: commenced 1 July 2014

Previous: **Mental Health Review Board of Victoria**

President: May 2010 – June 2014

Victorian Equal Opportunity & Human Rights Commission

Manager – Human Rights Unit: December 2006 – May 2010

Equal Opportunity Commission Victoria

Manager – Human Rights Law Reform: July 2005 – November 2006

Manager – Legal, Policy & Systemic Initiatives: August 2001 – July 2005

Acting Chief Conciliator & Chief Executive Officer: May – December 2004

Various complaint handling, policy and legal roles: commencing January 1994

Victorian Law Reform Commission

Acting Chief Executive Officer: August 2003 – February 2004

Overseas Secondments

British Columbia Human Rights Commission

September 2000 – February 2001

Hong Kong Equal Opportunities Commission

August 2000

PREVIOUS STATUTORY APPOINTMENTS

Chairperson

Psychosurgery Review Board of Victoria

May 2010 – June 2014

Deputy Chairperson

Victorian Infertility Treatment Authority and subsequently the Victorian Assisted Reproductive Treatment Authority

2009 – 2010

Sessional Legal Member

Mental Health Review Board of Victoria

2003 – 2010

Sessional Community Member

Intellectual Disability Review Panel

2001 - 2006

Community Visitor (Panel Secretary)

Intellectually Disabled Persons' Services Act

1997 - 2001

SELECTED PRESENTATIONS, PAPERS & PUBLICATIONS

2007 Report on the Operation of the Charter of Human Rights and Responsibilities (published by the VEOHRC and tabled in Parliament in April 2008)

2008 Report on the Operation of the Charter of Human Rights and Responsibilities (published by the VEOHRC and tabled in Parliament in April 2009)

Public interest v. private interest: Is there a shift from best interests to a rights-based approach? Council of Australasian Tribunals twilight seminar, September 2012.

Moving from compliance to engagement: Integrating the functions of the Mental Health Tribunal within the provision of support and treatment to compulsory patients. Multiple audiences during the consultation process informing the establishment of the Tribunal.

Respect, Recovery and Risk - Exploring the opportunities and challenges of a consumer-focused hearing in the civil and forensic jurisdictions of Mental Health Tribunals. Australian Institute of Judicial Administration Non-Adversarial Justice Conference, April 2017.

Constructive inquiry, clarification and reflection: the role of the Mental Health Tribunal in relation to treatment. Monash Health Professorial Lecture June 2017.

The Place of Risk in Decision Making Under the Mental Health Act. Monash Health Professorial Lecture Series July 2018.

Solution-Focused Hearings under Mental Health Legislation – Theory and Practice. Non-Adversarial Justice Monash University September 2019.

Impact of the Supreme Court decision in 'PBU' on the operation of the ECT provisions of the Mental Health Act. Office of the Chief Psychiatrist ECT Forum November 2019.