

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Wednesday, 20 May 2020 at 9.30am

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

1 CHAIR: Welcome to the Commission's panel discussion on
2 compulsory treatment. I am Penny Armytage, the Chair of
3 the Royal Commission into Victoria's mental health system.
4 I am joined by my fellow Commissioners, Professor Allan
5 Fels, Dr Alex Cockram and Professor Bernadette McSherry.
6

7 On behalf of the Commission I acknowledge Aboriginal
8 peoples as the traditional owners across all the lands on
9 which we locate for today's panel discussion and I pay my
10 respects to their Elders past, present and emerging.
11

12 Before we commence, I would like to acknowledge the
13 difficult nature of the subject that we are exploring
14 today. The Commission has heard from many individuals in a
15 number of forums about the impacts of compulsory treatment.
16 For many their experiences have been negative, demoralising
17 and life-changing.
18

19 For example, during last year's hearings the
20 Commission heard from Julie Dempsey about the profound
21 impacts of extensive and primarily unwanted
22 electroconvulsive therapy or ECT.
23

24 Julie reflected:
25

26 *You don't even know your personal self any*
27 *more. It doesn't just take away things*
28 *like memory and things like that, it takes*
29 *away your essential sense of being and*
30 *soul. It's quite devastating for me.*
31

32 A young woman shared in her 2020 witness statement
33 about the missed opportunities to intervene early and
34 perhaps avoid compulsory treatment. She said:
35

36 *I reflect on these three compulsory*
37 *admissions with sadness. I wonder how my*
38 *mental health trajectory could have been*
39 *different if the GP I'd seen in the lead-up*
40 *to my first episode had organised an urgent*
41 *psychiatric referral and I'd been supported*
42 *to sleep, if the CAT Team had come the*
43 *first time I called them and helped prevent*
44 *my second episode, and if the private*
45 *hospital had treated me adequately rather*
46 *than discharging me and prevented my third*
47 *episode.*

1
2 The Commission has also been told that for some people
3 fear of compulsory treatment can affect the way in which
4 they choose to engage with services and can cause further
5 distress. However, these experiences are not universal.
6 For some people their experiences include both negative and
7 positive aspects.

8
9 I was privileged to meet with Rick Corney a few weeks
10 ago. Rick generously shared his experiences as a consumer
11 as well as his work as a peer worker in a connecting to
12 community program in Ballarat. Rick had a number of
13 insights to share, however, on compulsory treatment he
14 wrote:

15
16 *I feel that my treatment as an involuntary*
17 *patient could have been more humane but the*
18 *intervention needed to happen for me when*
19 *it happened and I am grateful for the*
20 *treatment I received.*

21
22 I also recently met with Sandy Jeffs who reflected on
23 some of the negative and positive aspects of her
24 experiences in Larundel. Sandy recalled:

25
26 *If I hadn't been locked up in 1991 for*
27 *seven weeks in Larundel I wouldn't be*
28 *speaking to you today, so I understand that*
29 *some people need to be kept safe and people*
30 *need to be kept safe from them. I do*
31 *understand that.*

32
33 We have heard several positive aspects when we have
34 not anticipated them that speaks to the importance of the
35 Commission understanding the breadth of experiences. We
36 are cognisant that for each person the impacts of
37 compulsory treatment are very different.

38
39 We are grateful to Rick, Sandy and Julie and all those
40 who have shared their stories of compulsory treatment with
41 us. We appreciate that these are deeply personal
42 experiences that are not easy to retell.

43
44 We have also heard that for family members and carers
45 compulsory treatment is also extremely challenging. One
46 parent told the Commission:

1 *I understand and support everyone having*
2 *rights. I understand why the laws have*
3 *changed to protect people from forced*
4 *confinement in wards when they don't need*
5 *it. However, for those who need treatment*
6 *but maybe not recognise it because they are*
7 *delusional there needs to be processes in*
8 *place to ensure they get the help they*
9 *need. This is not fair to my daughter or*
10 *our family.*

11
12 Another carer conveyed to the Commission their
13 frustration with some of the current arrangements:

14
15 *As a nominated person I have found myself*
16 *frequently and actively excluded from key*
17 *clinical decisions regarding the compulsory*
18 *treatment of who I provide care for. This*
19 *has made it exceptionally difficult for me*
20 *to effectively fulfil my role as their*
21 *advocate while they are under a compulsory*
22 *order.*

23
24 In our interim report the Commission expressed concern
25 with the rates of compulsory treatment use and signalled
26 that this would be an area subject to further
27 consideration.

28
29 The Commission has heard on several occasions there is
30 an overreliance and overuse of compulsory treatment in
31 Victoria. Many point to research which suggests that rates
32 of compulsory treatment orders are higher in Victoria than
33 some other States and Territories. It is alarming that
34 around half of people admitted to public acute mental
35 health inpatient units in Victoria are done so on a
36 compulsory basis.

37
38 I want to emphasise that our examination of this issue
39 is not about laying blame or finding fault. Rather, our
40 enquiries are very much forward-focused. We want to
41 understand why compulsory treatment is used in the context
42 of mental health and the various impacts it has on
43 individuals.

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45 Importantly, we want to explore what role, if any,
46 compulsory treatment should play in the future system and,
47 if it is to be retained, how its use can be reduced and

1 people's experiences improved.

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1 We will all have heard of the mental health challenges
2 posed by the Covid-19 pandemic. Those challenges underline
3 and emphasise the important and continuing work of this
4 Royal Commission. Indeed, if anything, the challenges
5 presented by the global pandemic make the work of this
6 Royal Commission more relevant than ever.

7
8 Like many other court proceedings and public inquiries
9 in this time, the Royal Commission has embraced alternative
10 means by which that can occur. Today that means a Zoom
11 technology which allows the Royal Commission to receive,
12 hear and consider evidence in the form of a panel
13 discussion concerning an issue of critical significance,
14 namely, compulsory treatment.

15
16 At this point it's appropriate for me to ask Georgina
17 Coghlan of counsel to further introduce today's topic and
18 the eminent witnesses comprising the panel.

19
20 MS COGHLAN: Thank you, Mr O'Meara, and thank you, Chair.
21 As the Chair has said, I would also like to acknowledge the
22 difficult nature of the subject we're exploring today.
23 We've heard from so many people about the impact that
24 compulsory treatment has had on them and we continue to
25 hear from them.

26
27 I too extend thanks to Dr Vine, Professor Brophy,
28 Dr Maylea and Mr Carroll, who have all contributed so much
29 time and energy to this process for which we're very
30 grateful.

31
32 As the Chair mentioned, each panel member has provided
33 a written statement which will be published on the website
34 in due course. All panel members responded to a number of
35 questions, some of which will be explored further today
36 during the panel discussion.

37
38 The purpose of the panel discussion is to share ideas
39 on topics, identify points of disagreement and agreement as
40 the case may be. At this point I should point out some of
41 the topics that will be discussed today and introduce those
42 themes.

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44 We will be exploring the rationales and criteria for
45 compulsory treatment, considering the ways in which the
46 rates of compulsory treatment can be reduced, looking at
47 what needs to be in place in order to eliminate compulsory

1 treatment and alternatives to it, considering greater
2 safeguards, examining oversight mechanisms for compulsory
3 treatment, and looking at quality of care in service
4 provision and discharge.
5

6 The Commission appreciates there are broad approaches
7 to definitional questions when it comes to compulsory
8 treatment. For the purposes of this discussion today, we
9 will be approaching it without reference to restrictive
10 interventions, whilst acknowledging that that's an area
11 which is addressed by many of these witnesses on the panel
12 today and others in their witness statements and is, of
13 course, being explored in other ways by the Commission.
14

15 Can I now briefly introduce our panel members.
16 Dr Ruth Vine was recently appointed as the new Federal
17 Deputy Chief Medical Officer for mental health. She has
18 three decades of experience and expertise as a psychiatrist
19 and leader in mental health at Federal and state levels.
20

21 Her recent experience includes Director of the
22 Victorian Institute of Forensic Mental Health, Forensicare,
23 consultant to the Commonwealth and state departments of
24 health and the Eastern Melbourne Primary Health Network.
25

26 Professor Lisa Brophy is the discipline lead in social
27 work and social policy in the Department of Occupational
28 Therapy, Social Work and Social Policy at La Trobe
29 University. She is also an honorary principal Research
30 Fellow in the Centre for Mental Health in the Melbourne
31 school population and global health at the University of
32 Melbourne. She has a career-long commitment to the mental
33 health field with a focus on Community Treatment Orders.
34

35 Dr Chris Maylea is a senior lecturer in social work at
36 RMIT University. He is Chair of the Committee of
37 Management of the Victorian Mental Illness Awareness
38 Council, VMIAC. He is also a qualified lawyer providing
39 pro bono legal services through the Mental Health Legal
40 Centre. His particular areas of research are in the
41 intersections of health, welfare and the law with a focus
42 on mental health law, mental health social work,
43 involuntary mental health and program management
44 evaluation.
45

46 Mr Matthew Carroll is the President of the Mental
47 Health Tribunal. He has overall responsibility for the

1 operation of the tribunal and ensuring it performs its
2 statutory functions in accordance with the Mental Health
3 Act. As such in response to some of the questions today
4 Mr Carroll may provide only limited comment given the role
5 that he has.

6
7 Mr Carroll is a lawyer and has worked within a range
8 of independent statutory authorities in the fields of
9 anti-discrimination and human rights law, law reform and
10 mental health.

11
12 On that note, it's enough from me, I think everyone
13 would like to hear from the panel, so I'll commence with
14 the first topic.

15
16 The first topic that I'd like to discuss with the
17 panel today is the prospect of reducing the rates of
18 compulsory treatment. All of the panel members speak about
19 the need to increase service capacity and quality through
20 funding to reduce compulsory treatment.

21
22 Can I direct these first questions to Dr Vine and ask
23 you this: in order to reduce the rates of compulsory
24 treatment by increasing quality and capacity, is there a
25 model of care that should be considered?

26
27 PROFESSOR VINE: So, firstly, a model of care is, I think,
28 a difficult concept because it can be as big as you like,
29 but I think that the model of care I think has to enable a
30 range of different options and each of those options should
31 be available, as is indicated, by a person's level of
32 distress, by their clinical stability or acuity, and by
33 their need for a particular type or range of treatments.

34
35 I think, I have to say, you mentioned before that
36 Victoria has a particularly high rate. It's not unrelated
37 that Victoria has fewer beds per capita, particularly fewer
38 long stay beds per capita than any other state. So, when
39 we talk about a model of care, I think we also need to
40 think about the model occurring in a system of care and
41 that, to me, is a critical thing: you can't just say, oh,
42 let's reduce compulsion without thinking. We might need
43 earlier access to beds or longer access to beds, we might
44 need earlier access to intensive community treatment or
45 longer access to intensive community treatment and that
46 whole range of options.

1 So, my model care is that it should be state funded,
2 therefore no cost to the individual; that should enable a
3 range of options across community, bed-based and even
4 residential services that enables varying degrees of
5 intensity and varying degrees of safety - you highlighted
6 that for some people whatever the means of containment,
7 there needs to be some structures around a person to keep
8 them safe, and it should be for the duration that is
9 required.

10

11 MS COGHLAN: Just before we move on, I'll ask Dr Maylea in
12 a moment but before we move on from you, Dr Vine, can you
13 just address what the key components are within that model?

14

15 PROFESSOR VINE: So again, I'm assuming that this model is
16 the publicly funded mental health care which is for people
17 who cannot access care in other parts of the health system,
18 be it private or MBS or primary.

19

20 So, if I'm assuming that, then the components have to
21 be skill and an ability to provide treatment to those
22 illnesses and those presentations that comprise significant
23 disturbance of mood, thought, behaviour and perception, and
24 also at times significant episodes of crisis, and so, that
25 means you do need components that include clinical care as
26 well as psychosocial support of, you know, supports in
27 functional ability - and ideally supports to their broader
28 social context and that includes of course family and
29 carers, and I hope that's answered your question.

30

31 MS COGHLAN: It has, thank you, Dr Vine. Dr Maylea, can I
32 address that question to you in relation to the model of
33 care that should be considered.

34

35 DR MAYLEA: Yeah, thanks. I think it's a bit misleading
36 to speak of or to look for a model - care, as in a singular
37 model, I think that's one of the failings with the current
38 mental health system, that it is very much a
39 one-size-fits-all and it does work really well for a
40 proportion of people. But any model that, for example,
41 will see a lack of trauma incident care in the mental
42 health system as it currently stands, and I think any model
43 that seeks to be trauma-informed, is also going to miss
44 some other aspects, and so I think it needs to be about a
45 diversity of models and diversity of approaches and having
46 a range of services that are available, and that needs to
47 be not only a wider range within the system we've got but

1 also better integration, so family violence is very
2 obvious. And, I'm sure the Commission has heard a lot
3 about the need to integrate with that sector more, and in
4 terms of child sexual assault and trauma, that finds its
5 way into the mental health system that really never should
6 have arrived in the mental health system to begin with.

7
8 The next question then is, okay, we say we need lots
9 of different models, most people would agree with that; the
10 question is how do we ensure that people get the model that
11 suits them best. I think that's really about making sure
12 that the people who are using the services are in charge of
13 choosing the services that are going to work for them: that
14 means they need to be widely available, it does mean they
15 need to be free as Dr Vine's pointed out, but it means that
16 those that currently are making those decisions in the
17 mental health services system need to hand that power to
18 decide who gets what services back to individual people.
19 So that, it's people who are in the system using the system
20 who get to decide what model is going to work for them.

21
22 And so, looking for a single model or a generalist
23 approach I think is a problem in itself unless what we're
24 saying is, we need a model that allows people to choose the
25 model that is going to work for them. And also, to try a
26 few different models and have a crack at a few different
27 approaches, I think that's essential too, is that we allow
28 that diversity and that choice to occur throughout a
29 person's engagement with the system.

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31 MS COGHLAN: Thank you, Dr Maylea. Can we move on to
32 Professor Brophy.

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34 PROFESSOR BROPHY: Thank you very much and I agree with so
35 much of what both Dr Vine and Dr Maylea have already said.
36 I think though we have to be careful that we don't just do
37 more of the same and that we don't just try - I mean, we
38 have got a problem and I think Dr Vine's been very strong
39 on being able to tell us how much the current services have
40 been stripped away, and they haven't been enabled to
41 flourish in the way that we would hope, there's so much
42 potential in what we have, but they've been hamstrung by
43 poor funding.

44
45 But on the other hand, we also I think have to
46 acknowledge that there are long-standing problems that the
47 people who are accessing services, in particular people who

1 end up being subject to compulsory treatment, are
2 continuing to face and we haven't seen really strong shifts
3 in relation to those outcomes.

4
5 What I'm talking about is people continuing to have
6 difficulties in relation to social isolation, poor
7 opportunities for employment and education, poor housing,
8 all those kinds of issues, and that really says to me that
9 what we need is expanded options, as Chris was saying, and
10 we also need to be able to think about new innovations in
11 care that are actually going to start to address some of
12 those things that, when you ask consumers what they say is
13 really important to them, are often very much highlighted
14 in terms of their goals and unfortunately we don't have
15 services that are actually matched very well with trying to
16 meet those goals.

17
18 I think there's a couple of more things I wanted to
19 say just in terms of, one is that we have some really
20 interesting good models that we were already implementing
21 in Victoria and we need to be able to see them flourish and
22 we need good research around how those innovations are
23 going, so things like PARCs and post-discharge support and
24 those kind of things.

25
26 And then there are other innovations and there's been
27 examples overseas and in other parts of Australia where you
28 can see innovations around advanced care planning, and
29 crisis resolution and crisis houses, those kinds of models,
30 that I think again we need to start thinking about whether
31 we can draw some of that in. Then I think we need to do
32 really good research around those innovations to see
33 whether they are actually meeting expectations.

34
35 I suppose to build on that, I think all of this needs
36 to be based on really strong principles that might be
37 unifying so that, even though we might have lots of
38 opportunities for choice and control, if we have some
39 unifying principles then maybe that's what we mean by model
40 of care. So, if we think about principles around supported
41 decision-making or trauma-informed practice or recovery
42 orientated practice, it sort of sits around all of those
43 developments. I think that's important.

44
45 MS COGLAN: Thank you, Professor. Mr Carroll.

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47 MR CARROLL: Certainly, the tribunal wouldn't purport to

1 propose a particular model of care. I think I'd certainly
2 endorse what Lisa, Chris and Ruth have already mentioned.
3 I think there are a couple of things I would add which are
4 reflections on what the tribunal sees as frequent deficits
5 in the in-house care currently provided.

6
7 Look, the first one I'd mention has been examined in
8 detail and described very vividly in the Commission's
9 interim report, and that is that, through a crisis-driven
10 system of service delivery what that translates into is
11 incredibly traumatic and unsatisfactory first contact or
12 experiences at the point at which care is being initiated,
13 often involving police, often involving the security staff
14 of inpatient units, and it gives rise to - I don't want to
15 sound overly simplistic - but just the very real question
16 of, when that's your first contact with the delivery of
17 care and treatment why would you engage voluntarily after
18 that if things get off to an incredibly bad start.

19
20 The other thing which I would highlight is that, it
21 must be, whatever model or new models of care are in the
22 future, they need to strongly adhere or have a commitment
23 to facilitating or enabling longitudinal relationships
24 between those who are receiving care and those who are
25 providing it.

26
27 So much of what the tribunal observes at the moment is
28 care which you would describe as transactional rather than
29 relational, and often those transactions revolve around the
30 most contentious and fraught aspects of the relationship,
31 namely medication and in particular depot medication, and
32 these are interactions between people who often barely know
33 each other, or just as they begin to get to know each
34 other, there are changes in the make-up of treating teams
35 so that relationship never progresses and it's lost.

36
37 And the void that's left in the absence of a
38 longitudinal relationship is a void that is often filled by
39 protracted compulsory interventions because the foundation
40 isn't there for supported decision-making; the foundation
41 isn't there to understand what dignity of risk means in an
42 individual person's situation and, as I said, that gap or
43 that void is filled with a compulsory order.

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45 MS COGHLAN: Thank you, Mr Carroll. Does anyone want to
46 say anything further on this topic before we move onto the
47 next one?

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DR MAYLEA: Just to clarify my point about making sure people using services have the choices: that's both in terms of the people who are using services that day, but also in the design and the provision of services has to be done by and for consumers; that's the only way those principles of choice and control are going to be embedded in those services.

MS COGLAN: Thank you, Dr Maylea. If there's nothing further, we'll move onto the next topic. Thank you.

Next we're going to look at exploring the rationales and criterion for compulsory treatment. At the moment, as everybody knows, the criterion for the use of compulsory treatment is to provide immediate treatment to prevent serious deterioration in the person's mental or physical health or to prevent serious harm to the person or another, and all of you panel members have identified issues with that criterion in your statements.

What I'd like to do is just really explore what the criterion should be if compulsory treatment remains in existence. Can I start with you, Dr Maylea, and pose this question: if we started from zero and we're operating assuming that we will still have compulsory treatment for the purposes of this question, what should be the considerations for its use?

I'll ask you actually to consider three possibilities, but please address others. The first is whether it should look at a person not recognising they're unwell, or a person who is severely distressed or, thirdly, where there is a risk of harm to themselves or to others.

DR MAYLEA: Thanks. So, taking those one at a time, the question of capacity is - so, the idea that the person is not recognising they're "unwell" or they require treatment is inconsistent with the Convention on the Rights of Persons with Disabilities, it's inconsistent with international human rights law. We need to instead support people to exercise their capacity to make choices for themselves and that needs to be done on the basis of freely informed consent and to take any other approach is fundamentally discriminatory.

I guess, in terms of what can be done to improve

1 compulsory treatment, just before I come to those next two
2 points - or should improve the criteria specifically - the
3 criteria currently discriminates against people on the
4 basis of diagnosis, that is criterion (a), so that is the
5 discriminatory aspect and that needs to be removed. And,
6 of course, the general public would not tolerate being
7 involuntarily treated and that's why the mental health
8 legislation restricts that criteria (a). And so, the only
9 way to make mental health legislation non-discriminatory
10 and consistent with international human rights law is to
11 remove that requirement that it's a tacked diagnosis or
12 mental illness.

13
14 Stepping to experiencing severe distress, the idea
15 that another person can independently objectively assess
16 somebody's distress is an allusion really. The only person
17 who can convey their experience of distress is the person
18 experiencing that distress, and the idea that we would have
19 some kind of independent assessment - the tribunal I
20 imagine - rating people's distress? You know, it's just
21 preposterous that the tribunal can put themselves in the
22 place of person and say, well, this distress is severe and
23 this distress is not severe, it's an outrageous
24 proposition, and so, on that ground I don't think that's a
25 workable approach.

26
27 Absolutely, we should be saying to any level of
28 distress really, what support do you need, what can we
29 help? Are you feeling in distress? If so, here some
30 options that we think might help, which of these options.
31 So, as a way of providing services and support, and
32 people's own experience of distress can absolutely be used
33 as an organising factor for determining what might be
34 useful for them, but as a way of imposing coercion and
35 detention, yes, that's unworkable.

36
37 In terms of the third proposal, where there's risk of
38 harm to themselves or to others, the evidence is very, very
39 poor on risk of harm to self in terms of risk prediction;
40 we just can't do it and we really should stop trying. So,
41 in terms of risk of harm to self, there's no evidence base
42 for anybody's ability to do that.

43
44 In terms of harm to others, there's better evidence
45 for some things and the forensic system tends to do that a
46 bit better, but in general we're still so far below the bar
47 that would be required for detention for example in the

1 criminal system that, you know, as we do now, if we were to
2 keep the risk of harm to others criterion in, we're
3 detaining 20 people who wouldn't have gone on to pose harm
4 to others to prevent one person who would have, and so, you
5 know, that's distinctly and fundamentally unfair.

6
7 This is not a question of proving something beyond
8 reasonable doubt or even on the balance of probabilities.
9 Our ability to predict risk of harm to others is much, much
10 lower than 60 per cent, and so other than perhaps in a
11 very, very small number of cases, and you see those in the
12 forensic system, I don't think you can use the risk of harm
13 to others in a general mental health system if compulsory
14 treatment is to be maintained there.

15
16 And so, I think where that ends up is, either you have
17 a criterion that applies to the whole of the population and
18 protections so that it's not indirectly discriminating
19 against people who have a diagnosis, which it probably
20 inevitably would do, or you eliminate it altogether.

21
22 MS COGLAN: Thank you, Dr Maylea. Professor Brophy,
23 would you like to go next?

24
25 PROFESSOR BROPHY: I would like to comment on this more
26 broadly actually, because I think Chris has already
27 outlined a lot of the difficulties here.

28
29 If we go to questions of capacity then I think you
30 have some of the same problems as the risk criterion
31 because I think there's a view that capacity assessments
32 can be unreliable as well, and then we have this kind of
33 problem about the binary circumstances we might get into
34 about who's got capacity and who doesn't, and also there's
35 this issue of the compatibility with the CRPD.

36
37 But I wonder whether another way of even thinking
38 about this is to actually think about, have all the least
39 restrictive options actually been exhausted in this
40 situation, and do people actually know what the less
41 restrictive options actually are?

42
43 You know, my experience on the tribunal is that often
44 it's that criteria that's the one that is often most poorly
45 addressed, and I think sometimes it's because we have a
46 very narrow view of how we define treatment, how we define
47 the way we might care for someone in distress and actually

1 think about how we can do that in a way that doesn't mean
2 that we have to have goals that are not compatible with
3 that person's goals, so what are the opportunities that we
4 might have to actually enable a less restrictive option in
5 this circumstance.

6

7 At the moment I think one of our big problems is that
8 we have considerable limitations in being able to do that
9 because we don't necessarily have the kinds of systems and
10 supports in place that we would see as important.

11

12 So really having a strong sense of less restrictive
13 options, being able to really say that all of those options
14 have been exhausted and, if we don't act, then this person
15 may be of great harm to themselves or others, and perhaps
16 some strong justification can be given to that only in the
17 context that all other reasonable options have been
18 exhausted.

19

20 MS COGLAN: Thank you, Professor. Dr Vine.

21

22 PROFESSOR VINE: Thank you, and look, the first thing I
23 have to say is, in your introduction you pointed to the
24 criteria and you didn't mention the criterion No.1 which
25 Dr Maylea did, but I think that is absolutely critical
26 because this is actually a beneficent Act that is intending
27 to give treatment or enable treatment to be provided to
28 people who have, or under assessment appear to have, a
29 mental illness.

30

31 So you have to start by saying, do I believe that
32 there is evidence for these diagnostic categories that come
33 with a prognosis and outcome that are diagnosable mental
34 illness; do I believe in this medical and scientific
35 discourse that it is about psychiatric illnesses because,
36 if you don't, then all bets are off.

37

38 So, if we start by saying that people - the person has
39 a mental illness, then that I think informs your criteria
40 about attribution and distress.

41

42 So for instance, if I'm very distressed because I've
43 just learnt that I've got a terminal illness, or I've just
44 learnt that my mother's been murdered or something, I'm
45 very, very distressed, I'm going to need comfort and
46 succour and my family around me; whereas, if I believe
47 Commissioner Armytage is poisoning my soup and has stolen

1 millions of dollars and is out to kill me, I am also going
2 to be very, very distressed but my distress has a different
3 basis and has a different intervention.
4

5 I absolutely agree with what Professor Brophy said, I
6 think there's many things we can do around intervening
7 earlier or about providing a different range of options, I
8 have no argument with that, but I think the Commission also
9 needs to ask themselves, well, what would have happened if
10 we didn't have compulsory treatment; what would that have
11 done to our prison statistics or our suicide statistics or
12 our family disruption statistics?
13

14 And while I sort of agree with Dr Maylea about risk
15 being an uncertain science, I actually don't agree that
16 there is not benefit - this is of course self-serving so
17 forgive me - but I would like to think that I've developed
18 a degree of experience and that people working in the
19 mental health sector do bring clinical expertise to that
20 assessment - they don't always get it right, and mostly
21 there's probably more false negatives than false positives,
22 but they do it in an informed way and that's what they're
23 paid to do and it's what society expects them to do and, if
24 you went into a criminal court, you'd have expert witnesses
25 that were called upon to give evidence based on their
26 expertise.
27

28 And so, I think it's really important to remember that
29 the criteria starts with mental illness, that there's a
30 consequence that's linked to that that is about distress
31 and it is about risk and it is about a false attribution or
32 not recognising the internal cause of an illness.
33

34 And I'd also say, compulsory treatment should always
35 only be for a small proportion. We should be trying lots
36 of other ways - you know, most people's schizophrenia won't
37 need compulsory treatment because, if we had that early
38 intervention, if we had that therapeutic relationship and
39 engagement that Mr Carroll has talked about - I have the
40 "but", and I do think perhaps one of the other things I'd
41 just say in answer to this question is that,
42 notwithstanding Professor Brophy's comments, it is most
43 often the case that the tribunal when reviewing whether
44 that person does meet those criteria will be in agreement
45 with the clinical service. They might not be in agreement
46 with whether the relationship's as good as it should be or
47 were there shouldn't have been consideration of other less

1 restrictive options, but mostly they're in agreement that
2 the criteria are met. I think I'll stop there, I think I'm
3 getting carried away, I'm sorry.

4
5 MS COGLAN: Thank you, Dr Vine. We'll move on to you,
6 Mr Carroll, and then others can perhaps respond to what
7 Dr Vine has said if they so wish. Mr Carroll.

8
9 MR CARROLL: Thank you. Just briefly in relation to the
10 current criterion section 5(b), both in the tribunal's
11 original submission and in my witness statement identified
12 a number of concerns about it, but they're concerns about
13 what the tribunal regards as a misinterpretation and a
14 misapplication of that criterion rather than a formulation
15 of the criterion itself and it gives rise to some
16 perplexing scenarios and distortions to how I think aspects
17 of the Act were intended to operate.

18
19 With regard to the options that have been flagged, in
20 terms of a person not recognising they're unwell, I just
21 note that that is not a capacity criterion, that is an
22 insight criterion, and insight is another one of those
23 triggers that just gives rise to incredibly conflicted
24 discussions between treating teams and consumers.

25
26 The Supreme Court in PBU certainly recognised that the
27 notion of insight is a relevant consideration to forming a
28 view about a person's capacity, but it is not synonymous
29 with capacity and people who don't have insight can have
30 capacity. So, focusing on recognising whether a person is
31 unwell would be a backward step and one that wouldn't
32 contribute to some of the progress that we're hoping to
33 see.

34
35 With regard to whether or not the person is
36 experiencing severe distress, I'd suggest that whether or
37 not a person appears to be experiencing distress is
38 something which informs certainly the tribunal's current
39 consideration of whether it can be said that there is a
40 potential or actual serious deterioration in their mental
41 health or actual or potential serious harm to them, so it
42 is part of the fabric of what's being considered at the
43 moment.

44
45 I'm not sure that having it as a stand-alone
46 consideration would be necessarily helpful or an
47 appropriate focus, that it is more part of the broader

1 picture than the focus as such.

2

3 Whether or not there's a risk of harm to themselves or
4 others: I, or the Tribunal, I said before there are
5 concerns about the current misinterpretation and
6 misapplication of the current section 5(b) and it's
7 constantly referred to as the risk criterion despite the
8 fact that it doesn't include the term "risk".

9

10 Risk is one of those concepts which continues to
11 permeate the Mental Health Act even though the Mental
12 Health Act doesn't actually use it in the way that anyone
13 else is using the term "risk".

14

15 And a focus on risk is another one of those things
16 that very much narrows discussions. In the tribunal's
17 observation a focus on risk is reductive, it leads to
18 discussions where people are only being looked at as
19 sources of potential harm and looked at in terms of - to
20 use the ghastly term - their deficits rather than their
21 strengths and their potential, so I think we should be
22 avoiding giving risk any greater prominence in the Act than
23 it has despite it not actually being in there.

24

25 Also use of the term "risk" also feeds into a
26 misconception that, if we look hard enough, we can find a
27 risk-free response to a particular situation, and that is
28 again another fundamental myth. And the thing that's most
29 mythologised as a risk-free intervention is a compulsory
30 treatment order, but compulsory treatment orders have their
31 downside as well and they carry with them a sense of risk.

32

33 So, as you may have seen, I've got a bit of a pet beef
34 about using the term "risk" in any future formulation of
35 the criteria for treatment orders.

36

37 MS COGHLAN: Thank you, Mr Carroll. Would anyone else
38 like to contribute further? Yes, go ahead, Dr Vine.

39

40 PROFESSOR VINE: I think what Mr Carroll said is
41 absolutely correct, and of course we shouldn't have used
42 the word "risk", but the Act does suppose that there will
43 be harm, and it's to prevent and to minimise and to lessen
44 harm, and I think it's important to remember that.

45

46 The other thing that I'd just put in there is, the
47 people who draft these legislations are trying to meet

1 certain objectives, and one of those objectives of course
2 is to minimise the use of compulsory treatment and to make
3 it non-arbitrary, and I think the intent there is not -
4 and, you know, I just don't want you to in a sense pervert
5 the current structure of the legislation, which is that
6 those criteria are cumulative, they all have to be met, and
7 so, it's sort of a little bit false to think just if a
8 person was distressed, or just if there was an ability to
9 prevent harm, and that is why I think it's so important to
10 remind ourselves that it is about an illness and receiving
11 treatment.

12
13 I agree with what Mr Carroll said, of course there's a
14 risk to compulsory treatment and that risk is exacerbated
15 in a constrained system and exacerbated in a system where
16 the deficits are more prominent than the strengths like,
17 you know, lack of continuity of care and also a lack of
18 capacity, but there you go.

19
20 MS COGHLAN: Thank you, Dr Vine. Dr Maylea, would you
21 like to respond?

22
23 DR MAYLEA: Yeah, I guess my previous comments were at a
24 higher level. To drill down into specifically the existing
25 criteria I think to pick up where Professor Brophy left
26 off, the less restrictive criteria as it currently stands
27 is about a less restrictive way that the treatment can be
28 provided. So, one, there's no sense in which there's an
29 emphasis that, before compulsory treatment can be applied
30 for or involved, that there must be less restrictive ways
31 to reduce the risk of harm or the risk of deterioration.
32 So, all that (d) requires is that there's a less
33 restrictive way that the treatment's provided.

34
35 Now, if you could provide someone with housing, for
36 example, that's not part of the treatment or it's not
37 considered part of the treatment, and so, really if there
38 is to be a less restrictive criteria it must be much
39 broader and require that all steps have been taken to avoid
40 compulsory treatment or something like that. The word
41 "reasonable" needs to come out because that just allows
42 everybody to wriggle out of what they want to do.

43
44 And there needs to be some power somewhere, either at
45 the tribunal or with the health service, to require that
46 those alternatives can be provided, such as housing for
47 example, because now housing isn't reasonably available and

1 so it's just not considered as an alternative to providing
2 compulsory treatment. But any number of times if you were
3 to provide them with housing, you address the family
4 conflict, you would take away the serious harm element but
5 that's not how the criteria currently is. Is that clear,
6 sorry?

7
8 MS COGHLAN: Yes, thank you, doctor. Professor Brophy,
9 was there anything further you wanted to comment on that?

10
11 PROFESSOR BROPHY: I think it is making sure that we do
12 accept that we have a balance here. Commissioner Armitage
13 talked about people's experience of compulsory treatment
14 and the distress that they experienced and the way it's
15 shaped, the way they saw their ongoing relationship with
16 mental health services, and in many ways our criteria for
17 the use of compulsory treatment really needs to take that
18 into account.

19
20 And I'm not sure exactly how that can be expressed in
21 legislation, but we need to be able to say that what we're
22 actually doing is potentially causing harm, as Mr Carroll
23 said, and we need to be thinking about how we strike the
24 appropriate balance if we are to use it in the context of,
25 as I said, exhausting all other less restrictive options.

26
27 I really appreciate what Dr Maylea said about seeing
28 that more broadly than currently our quite narrow
29 definition of treatment.

30
31 MS COGHLAN: Can we just stay with you for a moment,
32 Professor Brophy. The next question is in relation to the
33 broad understanding that compulsory treatment is being used
34 to guarantee access to services.

35
36 PROFESSOR BROPHY: Yes.

37
38 MS COGHLAN: There may be some debate about that among the
39 panel members, but I understand it's all agreed that there
40 needs to be greater voluntary offering. But if we can just
41 stick with this idea that compulsory treatment is used to
42 guarantee services, what can be done to prevent that from
43 occurring?

44
45 PROFESSOR BROPHY: Look, I think in my research and
46 writing about Community Treatment Orders I've often said
47 that I think that this is a very long-standing unintended

1 consequence of Community Treatment Orders; that somehow
2 we've seen this situation where Community Treatment Orders
3 have become some kind of insurance policy, some way of
4 making sure that people are guaranteed service delivery
5 when they are discharged from hospital, and also a
6 guarantee that services will be responsive to them when
7 they're actually out in the community as well and, should
8 there be any sort of deterioration or whatever, that
9 there's a pathway back in.

10
11 A favourite quote from some research is where someone
12 said "it wasn't me that was put on the Community Treatment
13 Order, it was the service that was put on the Community
14 Treatment Order; they now have to look after me", and I
15 think this is kind of an interesting problem that seems to
16 have emerged, and why would it be the case that we're doing
17 that?

18
19 Well, you know, we have incredible pressure on our
20 inpatient units and people - well, one thing is that people
21 want to leave, they don't like being there, and the other
22 thing is that staff also want people to be discharged
23 because they need to make room for other people, and so, I
24 think often the Community Treatment Order is used again as
25 a way of safeguarding someone going home and it's seen to
26 be a protective factor around that and enabling a shorter
27 admission.

28
29 And then I think we have another problem there which
30 is about, well, why wouldn't we start using other skills,
31 why aren't we thinking about other ways of enabling
32 continuity of care and continuity of treatment? And some
33 of that I think sits with the structure of our services,
34 that they're so siloed, so that it actually becomes quite
35 difficult to be able to trust different parts of the
36 system, that they will respond appropriately, and so, when
37 we don't have that continuity of care I think sometimes a
38 Community Treatment Order is potentially used as a way of
39 compensating for that lack of continuity of care.

40
41 It may also sit with issues around skills. There are
42 some of us who have been concerned about the possibility
43 that CTOs have been deskilling, that we've been using them
44 for such a long time in Victoria and we've relied on them
45 for so long, that we haven't actually been more innovative
46 in terms of thinking about how do we undertake good
47 engagement with people within the system that we work in.

1
2 This kind of in some ways sits with this idea that
3 we've got this net widening of having more and more people
4 with all sorts of different presentations that end up on
5 Community Treatment Orders, even though in many ways they
6 probably should only be used more as a last resort, and
7 that's why perhaps our numbers are growing.

8
9 So, I think that means that we really need to be
10 rethinking how we understand issues like how to engage
11 people in treatment, how to respond to people who are
12 fearful of treatment. Again, Commissioner Armitage gave
13 really good examples of people who feared mental health
14 services and, you know, the idea that someone would be put
15 on a Community Treatment Order to deal with that fear is
16 really problematic when we're thinking about a kind,
17 compassionate service delivery model.

18
19 I think I'll stop there because I could go on for a
20 long time and I'm sure the others would like to comment.

21
22 MS COGLAN: Thank you, Professor. Mr Carroll, if we
23 could move to you on this topic.

24
25 MR CARROLL: Thank you. I certainly endorse what
26 Professor Brophy said and I remember from the conclave that
27 Dr Maylea and Professor Vine had other comments that I
28 strongly agreed with as well.

29
30 I wanted to approach it from a slightly different
31 angle, and it made me reflect on the role of the objectives
32 and the mental health principles that are presently in the
33 Act and I think from a tribunal perspective we would say
34 that they have been invaluable in breathing life, can I
35 say, into the other provisions of the Act, providing that
36 principled framework by which the interpretation and
37 application of all of the other aspects of the Act need to
38 be approached.

39
40 So the principles are a broad application but they
41 undoubtedly reflect the fact that they reside in a piece of
42 mental health legislation that is almost exclusively
43 focused on compulsory treatment and restrictive
44 interventions rather than having a broader focus or remit.

45
46 Look, I'm not suggesting that tweaking the Mental
47 Health Act is going to solve this particular problem or

1 conundrum overnight, but to look at whether consideration
2 be given to whether a broader suite of principles are
3 needed in the Act, and in particular dealing with access to
4 and provision of services more generally. So, for example,
5 reflecting that access to services should occur on a timely
6 basis and with an early intervention and with a prevention
7 focus, and also to recognise that there should be
8 equivalence of service provision across/between voluntary
9 and compulsory patients.

10
11 As the tribunal has said before in its submission,
12 being on a compulsory treatment order should only be about
13 the legal relationship that exists between the person and
14 their treating team; it should not be about their priority
15 in accessing services or the scope of services that they
16 access; what's available to them should be the same as
17 what's available to people who are voluntary and, in the
18 context of this particular issue, vice versa as well: a
19 treatment order shouldn't be some sort of golden pass to
20 knowing that you'll get treatment if you need it or being
21 able to get ahead of other people who are also waiting
22 should you need it.

23
24 So, as I said, that broadening of principles to
25 reflect objectives such as that might be something that
26 warrants consideration.

27
28 MS COGLAN: Thank you, Mr Carroll. Dr Vine, would you
29 like to comment on this topic.

30
31 PROFESSOR VINE: So, we're talking about whether
32 compulsion is used to get services?

33
34 MS COGLAN: Yes.

35
36 PROFESSOR VINE: So, I just do want to remind the
37 Commission that at the beginning of my witness statement I
38 think I said that, just about every aspect of the public
39 mental health service in Victoria has been distorted to
40 some extent because of the constraints in service
41 provision, and I think that's very important to bear in
42 mind.

43
44 I agree with what my fellow panellists have said, in
45 particular as Mr Carroll was just talking, that a person
46 should be able to have the same range and quality of
47 treatment whether or not they're on a treatment order.

1 It's a mechanism, it's not the treatment, so I think that's
2 important.

3

4 I think I have said that I did not think that the
5 treatment order was used in order to get people to
6 services, and the reason that I say that is, there's
7 another side to this as well which is that, when services
8 are very skinny in fact people are taken off orders and
9 allowed to sort of wander off into the blue distance, or
10 they are discharged to their GPs early and taken off an
11 order, when the service knows full well that the risk that
12 they will drop out of treatment and they will drop out of
13 service and there will be a relapse, they know that full
14 well to be - I won't use the word "risk" - but is a likely
15 event.

16

17 And so, I think that there is actually also a problem
18 here: there's a lot we don't know about compulsory
19 treatment. I mean, in principle we think that it is wrong
20 for people to be compelled when they are citizens and their
21 rights should not be taken away, but actually we don't have
22 very good evidence to know whether there are variants of
23 orders or orders that in fact, if they were in place for
24 longer, would actually lead to a much better experience of
25 care and a much greater likelihood of not having relapses
26 with all of the trauma and distress and drama that goes
27 with that.

28

29 I think the short answer I guess is, we don't know,
30 but I think both happen and I absolutely agree that a
31 treatment order, whether it's an Inpatient Treatment Order
32 or a Community Treatment Order, it is the mechanism to get
33 to the right sort of treatments and supports that might
34 include housing support or family support or vocational,
35 but it's the means to that, not the end of that. Thank
36 you.

37

38 MS COGLAN: Thank you, doctor. Dr Maylea.

39

40 DR MAYLEA: Yeah, there's a lot there. I think, number
41 one, if services were really nice, and the people providing
42 them are really nice - and sometimes they are and often
43 they are, but as often they're not, at least as often
44 they're not - people would use them and so we wouldn't need
45 Community Treatment Orders.

46

47 I think, coming back to Mr Carroll's point about not

1 being taken there by the police, very briefly I'll share an
2 illustrative example. There are a number of inpatient
3 units across the state where you're only allowed two cups
4 of tea or coffee a day, for example, at 10 o'clock in the
5 morning and 3 o'clock in the afternoon and, if you want tea
6 other than that you have to request it, and so I observed
7 an interaction where the person was asking for a cup of tea
8 outside these times and was told, "Look, I'm sorry, this
9 isn't a hotel" and I thought, why not? Why isn't this a
10 hotel? Why isn't this nice with room service? It's way
11 more expensive than a hotel. You know, in terms of cost
12 per night it's five stars, why can't I get a cup of tea
13 whenever I want a cup of tea? And so, I think that's what
14 we're missing here. Just to kind of illustrate that and
15 flesh that out, is that, I think I spoke in the conclave
16 about some of the facilities at Forensicare that aren't
17 provided elsewhere at Thomas Embling. You can play in a
18 band at Thomas Embling, you can go to the cafe, you can do
19 things that in another inpatient unit just aren't
20 considered acceptable for some reason, so I think that's a
21 big part of it; if the services were of sufficient quality
22 you wouldn't be using them.

23
24 I absolutely agree with Professor Brophy's point, I
25 think clinicians have become quite lazy in terms of
26 engaging with people because they know that they can use a
27 Community Treatment Order and, as soon as they apply for a
28 Community Treatment Order, it makes it look like it's the
29 person's fault that the relationship's broken down - maybe
30 not the person's fault but, you know, you just don't have
31 to work as hard to engage because at the end of the day if
32 you have to you can just apply for a CTO and you know you
33 can get one, so I think that's a big part of it.

34
35 Third and finally, I'd say, and I think I put this in
36 my witness statement, I've written about this elsewhere,
37 that it would be fantastic actually if people could get an
38 order against the service to provide them with the service
39 they need. If they could apply to somewhere like the
40 tribunal, and I don't think this is - you know, Mr Carroll
41 said "We won't solve this by tinkering with the Act": this
42 is actually not that difficult to address. I appreciate
43 this is quite a novel concept legally, but if we can apply
44 to the tribunal and say, I want this service to provide me
45 with this kind of service, or this kind of housing, or this
46 kind of regularity of engagement, that would be fantastic.

47

1 I mean, obviously there are all sorts of resourcing
2 issues around that, but absolutely I would love to see that
3 spun around so that people could apply to the tribunal or
4 some other body and then the service would be required to
5 be provided to them. Because we see people - there's just
6 as many people who can't get into the mental health system
7 who want to get in, or who aren't getting what they want
8 from it, as there are people who are trying to escape or
9 otherwise reduce the coercion in compulsory treatment. So,
10 yeah, that's all.

11
12 MS COGHLAN: Can we just stay with you, Dr Maylea, for a
13 moment. I actually want to move on to the next topic
14 unless anyone else has anything to add to that discussion.
15 Sorry, go ahead, Professor Brophy.

16
17 PROFESSOR BROPHY: Thank you so much. I just want to say
18 that, I think one of the other things I think I mentioned
19 in my statement that I think's important here, is that we
20 also see variation in this phenomenon as well, and we don't
21 know very much about that variation: why it exists, why we
22 have some services who use CTOs a lot and some services
23 that don't seem to use them quite as much. And we don't
24 know enough about why that's happening, except that we can
25 see that that also happens in relation to other areas of
26 restrictive practice as well, we see this variation.

27
28 I wonder whether this says something about the culture
29 of services too, which links back to the issue of how
30 prepared services are for engaging with people voluntarily.
31 But you do wonder whether there are particular cultures
32 that develop around the use of compulsory treatment and
33 whether there's some complacency that is fostered in some
34 services, perhaps through lack of good oversight, or lack
35 of good management and leadership, or good engagement with
36 co-design and consumer engagement and involvement.

37
38 I just wonder, and I'd have to recommend that we
39 really start thinking about why we see that variation in
40 this context.

41
42 MS COGHLAN: Professor, just before we move on from that,
43 can I just ask then, how do you drive a cultural change?

44
45 PROFESSOR BROPHY: Well, isn't that interesting? I think
46 we'd love a magic wand to change culture; in fact, even
47 defining what culture is can be difficult. But I think

1 there are a number of different strategies that, in the
2 mental health context, we can think about.

3
4 We are already seeing successfully driving cultural
5 change and I think one of the things is by giving service
6 users a voice, so giving consumers more of a voice, and
7 that has to be meaningful, and people have to know what
8 they're talking about. There's a lot of difference between
9 collaboration, co-design and co-production, and yet all of
10 those terms all get used synonymously and they're not - we
11 need to be more aspirational about how we can actually
12 engage consumers in actually having a genuine role in
13 implementing service delivery and helping to drive service
14 improvement. So, that's one area.

15
16 Then cultural change I think also potentially relates
17 to resources as well. I think if services have learned
18 that things aren't going to change and that we're just
19 going to have to operate this way, and more and more is
20 likely to get taken away, I think it's very hard for people
21 to make that shift.

22
23 I've always said that I don't think resources is
24 enough of an answer, because you can see a service that has
25 the same level of funding and there's treatment team A and
26 treatment team B, and yet treatment team B seems to operate
27 in a very different kind of way. So I think it's more, I
28 think it is about values and principles and the way they
29 are embedded into practice, and that probably relies on
30 really good supervision, management, leadership,
31 accountability. And I think the degree to which people
32 recognise the harms that are associated with compulsory
33 treatment might be part of it.

34
35 The other thing is that we have this whole issue of
36 the social determinants and the degree to which services
37 are very aware of the context in which they're working and
38 able to engage with that, and I think that's often quite
39 difficult for services to do, but that's also another
40 important aspects of cultural change I think, for services
41 to be seen to be more outward focused in terms of thinking
42 about their place in a broader system.

43
44 MS COGLAN: Thank you, Professor. Would anyone else like
45 to comment on that cultural change aspect before I direct
46 the next question to Dr Maylea?

1 DR MAYLEA: Yes, just very briefly, I think it's important
2 to note that we don't know which services or who use which
3 services; that the data is not transparent and is
4 inconsistently collected. And so, we're still a few steps
5 away from being able to tackle that fundamental problem
6 because we don't know where this is happening. We see it,
7 whenever we go looking for it we can find evidence of this
8 disparity, but where and how and who, we just don't know.

9

10 MS COGLAN: Thank you. Dr Vine.

11

12 PROFESSOR VINE: I was going to say some of the things
13 that Lisa - sorry, Professor Brophy's highlighted, but I
14 would add to that, that Dr Maylea referred to the five star
15 hotel and it should be a hotel. I do think there is - part
16 of the culture here is the discrimination that we see
17 against mental health services, and staff and clients or
18 patients, in terms of the amenity and the quality that's
19 provided in that, and I think that that sort of permeates
20 sometimes people's sense of themselves.

21

22 Of course, we can do great service in a tent, there's
23 no doubt about that, but I think there is a general view
24 that, if people want to come to a clinic, if they want to
25 stay in an inpatient unit, everything becomes less harsh
26 and I think that that's an important element that affects
27 both staff and patients.

28

29 I do have to say that, we are talking about equity and
30 people's accessibility to a service and, if services were
31 like Dr Maylea would like and like the magic pudding, we
32 could whistle up plum duff or whistle up steak and kidney,
33 but in fact we are in a situation where this is a public
34 service that needs to be able to provide services to the
35 most socially disadvantaged and the most - the person
36 facing the most socio-demographic and socio-economic
37 challenges. So, there is that balance here between equity
38 of access and rationing what is always going to be a finite
39 resource.

40

41 DR MAYLEA: I am going to seriously agree here. If you go
42 to Peter Mac you can get a massage and a pedicure. Can you
43 imagine going into a suburban mental health unit and being
44 offered a massage and a pedicure? I appreciate we have
45 resourcing limitations, but so do Peter Mac. Peter Mac
46 have that exact same situation, having to make choices
47 about balancing resources and they have more, I appreciate

1 that, and yes, I agree that mental health has been
2 discriminated in some way, but that is what's being done.
3 There are libraries; like, it's phenomenal, and yet we
4 don't even - anyway.

5
6 MS COGHLAN: Yes, Professor Brophy.

7
8 PROFESSOR BROPHY: I hope you don't mind, there's one more
9 thing to say about this and perhaps - I agree, there is so
10 much evidence that the design of services and the amenities
11 of services have an incredible impact on people's
12 experience of them. In fact, it's really interesting to
13 see the research about PARCs, because PARCs are such
14 pleasant places to go to, they're lovely, and people see
15 that and their high levels of satisfaction are often linked
16 to the very pleasant environment that they're in.

17
18 Anyway, the other thing is that, pedicures and so
19 forth would be great, but we don't even have people who get
20 universal advocacy even in the context of their human
21 rights being incredibly impacted by a compulsory treatment
22 order. They don't - I mean, it seems to me that they're
23 the kind of absolute fundamentals that we also need to
24 think about in this context, and I do believe that
25 increased advocacy is another opportunity to drive cultural
26 change. And increased accountability and increased
27 discussions about why compulsory treatment is actually
28 being required, what's going on, what's going to enable
29 this person to get access to a less restrictive option.
30 Having independent people who can help drive those
31 conversations is actually, I think, really important.

32
33 MS COGHLAN: Thank you, Professor. Dr Maylea, can we move
34 onto the next topic. As all the panel members know, there
35 are differences of opinion as to whether or not compulsory
36 treatment can be eliminated.

37
38 Can I ask you this question: what needs to be in place
39 in order for compulsory treatment to be eliminated?

40
41 DR MAYLEA: I think to start with, we need to eliminate
42 it. I think that's probably the - certainly this is not -
43 the position that I'm proposing and that VMIAC adopts is
44 not a (indistinct) dying with your rights on. We're not
45 suggesting that we don't fill the gap in terms of providing
46 services and support that compulsory treatment is currently
47 purported to fill, so this is much more about a human

1 rights position than a civil rights position.

2

3 People are entitled to - and it's all laid out there
4 in the CRPD - people are entitled to the services and the
5 supports that they need and, when they are provided
6 we don't - you know, air quotes - we don't need compulsory
7 treatment.

8

9 So I think, while it is still there, while that tool,
10 while that hammer is still there, we still see every
11 problem as a nail that can be hit with that hammer and
12 addressed in that way. So we need to take that tool out of
13 the hands of - certainly out of the hands of clinicians,
14 and take it out of the mental health services so that
15 mental health services are forced to adapt, and then to put
16 in appropriate responses, and we enable those services and
17 provide those responses.

18

19 I think there's a range of other things that need to
20 occur as well. There's certainly a need for change in
21 community services - sorry, in the broader community and
22 the way that people understand odd behaviour and people who
23 are presenting different world views. I think Dr Vine's
24 already referred to the interactions with the prison system
25 and the legal systems that would need to be addressed
26 there, but yes, fundamentally that needs to be the starting
27 point.

28

29 I appreciate that's unlikely to be recommendation
30 number one in the final report, and so, perhaps I might
31 propose that at the very least a goal of elimination, and
32 there's an approach that says it is expected of services
33 that they won't use involuntary treatment and a strategy
34 for working towards that.

35

36 Similarly, we've fallen off the rails a bit, but as we
37 have with seclusion and restraints. We did, we talked
38 about elimination of seclusion and restraints, we then got
39 distracted and focused on something else instead. I think
40 that kind of language, that kind of approach will put us in
41 the right direction; as long as we say, oh, we're just
42 trying to reduce it rather than eliminate it, no matter how
43 that works, the new Act was supposed to reduce it and we've
44 only seen it increasing.

45

46 But, having said that, I return to my first point
47 that, if that option is there for services to use, we have

1 seen consistently that they will use it, so we need to take
2 that option away somehow or limit it somehow, severely
3 limit it somehow.

4
5 MS COGHLAN: Dr Vine or Professor Brophy?

6
7 PROFESSOR VINE: Okay? Look, thank you. I mean, a few
8 things of course, it comes back to my earlier point about
9 whether people believe that a thing called mental illness
10 exists and as a civilised society we have a responsibility
11 to provide care to people who may be experiencing that.

12
13 But a couple of things: I would just first highlight
14 that being under the Mental Health Act actually brings
15 protections. It brings a right to external review, it
16 brings a right to nominated persons. I mean, I sometimes
17 worry about interventions provided to people who aren't
18 under the Act, and aged care is a great example, where
19 terrible things can happen and they're invisible because
20 there is no exposure. So, I just remind the Commission
21 that the Mental Health Act brings rights.

22
23 I think the other thing that we have to highlight too
24 is that, compulsory care for people with mental illness
25 does not exist in a vacuum, and so, in a work environment
26 health services are obliged to work within the WorkCover
27 and WorkSafe constraints, and suicide of an inpatient is a
28 sentinel event, and even a community suicide is a coronial
29 report to the Coroner for an investigation and part of that
30 investigation will be about the adequacy of services, and
31 part of that investigation will be whether a person should
32 have received more assertive care or more intensive care,
33 so we need to realise that having - so I'd start by saying
34 my own view is, I'd love to minimise the use of compulsory
35 care, but I think if we look at countries that don't have
36 the rights and protections that go with mental health
37 legislation, we see people confined to cages, tied up to
38 trees, we see the numbers of people in prisons, you know,
39 more than 50 per cent having a significant mental illness,
40 we see the homeless populations - you know, misery, just
41 misery, I just don't know how any person could accept that.

42
43 But there's the Act and then there's the context in
44 which the Act sits and all the requirements that exist on
45 the service provider and clinicians down to individual
46 clinicians, and part of that - part of that - is about
47 providing treatment and care within the framework that

1 enables that to happen in a way that is both effective and
2 safe. And I'm absolutely not saying that we shouldn't be
3 doing a heap better, I hope I've emphasised that the
4 service is not as it should be, but I don't think you can
5 take away from compulsory care.

6
7 Look, I think - do you remember Cornelia Rau? You
8 know, what a saga that was and effectively she and her
9 family would not have had the misery that they'd had if
10 she'd had access to compulsory care rather than having to
11 go through various detention centres and all of the things
12 that followed. I mean, hers was a very public example of
13 what happens when a person tries very hard to evade
14 systems, but there are many, many examples of unfortunately
15 where people either don't come forward or actively
16 disengage and, when treatment is provided, it is of
17 benefit. Treatment is beneficial, I think that's a really
18 important thing, to me, to get across. Thank you.

19
20 MS COGHLAN: Thank you, Dr Vine. Professor Brophy.

21
22 PROFESSOR BROPHY: Look, I hope I'm not being too
23 self-serving here, but I think research is a very important
24 part of this because I think there's a lot we don't
25 understand about who ends up on a compulsory treatment
26 order and why.

27
28 What we know internationally is that poor and
29 disadvantaged and people from CALD backgrounds are much
30 more likely to end up on compulsory treatment orders, and I
31 think we probably all agree that that is something that
32 would be of concern. We don't really know why, and we need
33 to investigate those kinds of things to actually start
34 thinking about, what is - you know, are there fundamentally
35 discriminatory aspects of how we apply compulsory treatment
36 and what do we do about shifting away from that.

37
38 Then I also might - it speaks to the idea that, if
39 we're going to do anything about compulsory treatment we
40 need to think more broadly around those issues, around the
41 social determinants. We've already mentioned the problems
42 of people not having safe and secure housing, the problems
43 just in our services, not doing enough family work, for
44 example.

45
46 Often Community Treatment Orders are put in place
47 because families are scared and worried, and yet, we don't

1 necessarily then respond by seeing the family then as part
2 of the solution potentially, and doing work with families
3 that actually helps to think through what are the least
4 restrictive options; inviting them into the conversation
5 about why we might want to move away from compulsory
6 treatment to another option. And, I can understand that
7 families might be really scared of any kind of change when
8 they feel so let down by the system up till now.

9
10 So what I'm trying to say is, in my statement I
11 mentioned that Edwina Light had found that we'd dropped the
12 number of people on Community Treatment Orders. Now, you
13 would have thought that from all of what I've been ranting
14 on about for years I'd be quite delighted about that, but
15 I'm with Ruth on this one because - or I should say
16 Dr Vine - but I think that's really problematic because I
17 don't see any increase in service delivery, I don't see any
18 increase in any of the kinds of things that I've suggested
19 for many, many years we need to set in place to reduce the
20 use of Community Treatment Orders and compulsory treatment,
21 and so, is this just a sign of benign neglect? And, if
22 that is, that's a dreadful unintended consequence of our
23 efforts to try and reduce compulsory treatment.

24
25 So, I'm really sitting in the place of saying, if we
26 really want to reduce compulsory treatment we have to
27 acknowledge all the different issues that we've been
28 talking about, about why people might end up on a
29 Compulsory Treatment Order and then build a system that's
30 actually around trying to genuinely develop alternatives
31 and, as I said before, really genuinely develop what are
32 these least restrictive options that we kind of talk about
33 but we may not actually genuinely have available to people.

34
35 MS COGHLAN: Thank you, Professor. Mr Carroll, I
36 understand you didn't want to directly comment on this
37 question, but is there anything you'd like to contribute?

38
39 MR CARROLL: What the question prompted me to reflect on
40 was the consultation and the discourse that preceded the
41 enactment of the current Act which carried a lot of
42 expectations that there would be - it would be the trigger
43 for a significant reduction in Victoria's acknowledged high
44 rates of reliance on or use of compulsory treatment, and
45 it's at best a marginal realisation of some of those
46 objectives and possibly not even that.

1 It strikes me in hindsight, and there are many others,
2 other panellists and there are many others
3 observing/listening today who would be part of these
4 discussions as well, but on reflection the information that
5 was provided was essential and it was very comprehensive,
6 but it wasn't comprehensive enough.

7
8 There was a lot of discussion about the, sort of the
9 foundational underpinnings of why we were going this way,
10 and people do absolutely need to understand the broader
11 context within which these issues sit, the international
12 framework of human rights and the domestic Charter as well.
13 Then there was discussion about how the criteria and the
14 provisions of the Mental Health Act would be re-configured
15 to try and promote less reliance on compulsory treatment.

16
17 But look, I'm not saying definitively that these
18 discussions didn't occur, but I can't recall any
19 discussions where clinicians and others were given a
20 satisfactory response to the question of, well, you're
21 telling us don't do this, but how do we do it differently;
22 what do we do instead?

23
24 And so, there needs to be - the theory is critical,
25 I've worked in human rights for years, so of course I'm
26 attached to the international covenants, but they don't
27 give clinicians on the ground an answer to managing
28 incredibly complex, fraught situations in real-time and I
29 don't know if sufficient work was done to say, okay, this
30 is what we're envisaging or expecting as the alternative.

31
32 The other things that I think were missing was that
33 there was really no effort to develop greater risk fluency
34 within the broader community. We're telling people to be
35 less risk-averse in their decision-making, but they know
36 that they're making decisions which at some point down the
37 track will be judged quite narrowly, and that, the
38 questions that are asked aren't so much about whether what
39 was done - there isn't necessarily a thorough explanation
40 of whether all relevant considerations were taken into
41 account and the law was applied as was expected. Instead,
42 people are asked, why didn't you do this to stop this
43 happening, as if they had the ability to predict the future
44 and they had before them an intervention that - a
45 compulsory intervention that would stop a crisis or even a
46 disaster occurring.

47

1 So we need greater risk fluency in the community and
2 we need, I think, to challenge our own blame culture which
3 exists within mental health and indeed more broadly.

4
5 MS COGHLAN: Thank you, Mr Carroll. Would anyone else
6 like to say anything further on that topic?

7
8 DR MAYLEA: Just, as I mentioned in my statement, it's
9 essential for people who do prefer compulsory treatment to
10 be enabled somehow to have access to it, whether that's
11 through an advance statement or through some other means,
12 and also, that there are safeguards put in place around
13 that. So, absolutely in the same way that is afforded to
14 the general population to make binding commitments about
15 future events, that needs to be validly provided as well,
16 so it's really about elimination of involuntary treatment
17 that people don't want rather than excluding that as a
18 treatment modality for people who do identify that they
19 want to use it. And obviously there's difficulties in how
20 that's implemented, but yes, they need to be ironed out
21 obviously, but I don't want my proposition to be taken as
22 preventing people who identify themselves, that they prefer
23 involuntary treatments to be denied that option.

24
25 MS COGHLAN: Thank you, Doctor. Professor Brophy.

26
27 PROFESSOR BROPHY: Another thing I'd like to say about
28 this is that, for a long time we've had the situation in
29 Victoria that even though we've had high numbers of people
30 on Community Treatment Orders, for example, they've been
31 relatively invisible. What I mean by that is that, this
32 issue isn't discussed very much in our policy, in our
33 rhetoric in terms of how we want services to operate.

34
35 There's been some good looks at various policies and
36 it's actually quite difficult to see, how do you translate
37 recovery-orientated practice for example to people on
38 Community Treatment Orders. We tried to do that in the
39 PULSAR project, but up until then recovery orientated
40 practice frameworks that were guiding practice weren't
41 necessarily directly speaking to what that means for your
42 large numbers of people who are subject to compulsory
43 treatment.

44
45 Similarly, in our shift towards supported
46 decision-making: again, we haven't been clear in guiding
47 how that's actually going to work for people who are on

1 Compulsory Treatment Orders. So, it really says something
2 about the level of skill and sophistication that we require
3 to enable that to happen, but it also says that at a high
4 policy level we need to be much clearer about providing
5 good guidance, and maybe that's about codes of practice
6 that actually support people in the work that they're
7 doing, because otherwise I think we do struggle with this
8 sort of invisibility, and they're the people over there,
9 we'll do the work we'd like to do with the people who are
10 all voluntary or whatever, and then even then that's
11 becoming more and more difficult to do.

12
13 So, I just wanted to add that to the discussion and
14 say that we need to be more transparent about Community
15 Treatment Orders in general.

16
17 MS COGHLAN: Thank you, Professor. I'm just noting the
18 time is now just 11 o'clock. What I propose is to have a
19 10 minute break.

20
21 Can I just flag that when we come back I'll be asking
22 you, Professor Brophy, about paragraph 25 of your
23 statement, where you refer to particular research for
24 indigenous and CALD communities. So, I just flag that. If
25 people wish to read that paragraph before we come back,
26 they may, but otherwise see everyone in 10 minutes. You've
27 got nowhere to go, so I'm hoping that that's long enough.

28
29 SHORT ADJOURNMENT

30
31 MS COGHLAN: Perhaps we can now recommence, thank you,
32 everybody. As I foreshadowed just before the break, the
33 next topic is a narrow one and I'd like to address this,
34 first of all, to Professor Brophy.

35
36 It's in the context of what you refer to at
37 paragraph 25 of your statement, I'm not going to repeat
38 that here, but in broad compass that deals with research in
39 Queensland that reflects that people from CALD backgrounds
40 and indigenous Australians are more likely to be
41 compulsorily detained, whether that's in hospital or on a
42 Community Treatment Order.

43
44 In the context of that proposition, firstly, do you
45 have any views about how that can be addressed and what is
46 it about service characterisation that makes that happen?
47

1 PROFESSOR BROPHY: I think we should congratulate Steve
2 Kisely and his colleagues for doing that research, because
3 it's really good to get some evidence from Australia that
4 this is happening, because it's actually not just an
5 Australian problem, it's an international problem. The UK
6 are also struggling with this and having an
7 overrepresentation of people from marginalised communities
8 who are more likely to be on compulsory treatment orders.
9

10 I should mention that, in relation to the indigenous
11 community, the results there are mixed. The same
12 researchers conducted work in Western Australia and didn't
13 find that people from indigenous communities were
14 over-represented, and even some research I did many, many
15 years ago, one person in 164 was a person from Aboriginal
16 Torres Strait Islander background. But we do have this
17 more recent evidence from Queensland, so it is very
18 worrying.
19

20 The CALD community in particular seems to stand out as
21 being consistently over-represented and I think there's
22 probably a number of issues going on here and they probably
23 intersect with some of the kinds of issues that we've been
24 talking about.
25

26 If we think about people having been more likely to be
27 exposed to poverty, more likely to be exposed to trauma,
28 then potentially there's a compounding effect.
29

30 The other issue is whether we also have problems about
31 the accessibility of our services and whether they are
32 culturally sensitive, whether they're actually able to be
33 responsive and really genuinely, you know, have equity of
34 access.
35

36 And so, the problem might be that, without that equity
37 of access, you have people who are arriving at services or
38 ending up in services in a much more distressed state and
39 therefore they end up - they're more likely to end up on a
40 compulsory order.
41

42 So, what would improve the accessibility of services
43 and their equity of access? I think it really comes down
44 to whether we actually have services that are responsive to
45 cultural differences, you know, all the way through from
46 the simple manner of making sure that there's interpreting
47 services available and they're consistently available. The

1 other thing is also having - potentially having people from
2 different cultural backgrounds well represented in
3 services. There's the potential for peer support roles to
4 be extended into people from CALD backgrounds who can
5 perhaps help connect and engage people in services.
6

7 There's also that possibility that what we're seeing
8 is these problems that we have with our workforce, that we
9 just have a workforce who aren't well trained for the work
10 they're doing, aren't well prepared for that work, and
11 don't necessarily see that part of their preparation needs
12 to be about being able to acknowledge that we have a
13 diverse community in Australia and we need to be well
14 prepared for working with people across different cultural
15 groups.
16

17 The other thing that was mentioned in that article
18 that I think is important here is also these issues about
19 how we might determine mental illness in different cultural
20 contexts, and that's where, again, that needs a
21 sophisticated and nuanced appreciation of what's happening
22 for someone, and being genuinely interested in their
23 cultural and spiritual needs and issues and being able to
24 apply that appropriately.
25

26 So they're just some of the issues that I think sit
27 behind this finding.
28

29 MS COGHLAN: Thank you, Professor Brophy. Would other
30 panel members like to comment on this topic?
31

32 DR MAYLEA: Mainly to support Professor Brophy's comments,
33 I'd also add that a large part of the mental health
34 workforce does come from overseas, it doesn't always have
35 in particular training experience or work with First
36 Nations people, and also often coming from places where
37 there isn't the same cultural diversity or the same dynamic
38 of cultural diversity that play out here.
39

40 And certainly, personally I have seen that play out
41 any number of times with the tribunal. The most common
42 example is where the orders being sought in relation to a
43 woman and she doesn't want to talk in front of the
44 tribunal, in front of people she doesn't know, about her
45 experiences of trauma or family violence in particular.
46 That, I can't even count the number of times I've
47 experienced that, and so, she doesn't want me to say

1 anything to the tribunal and the tribunal makes a decision
2 having no idea of the context or of the background.

3

4 And so, I think, just seeing that myself, I can see
5 that that's playing out as a way of kind of adding a bit of
6 colour to the statistics that Steven Kisely presented.

7

8 MS COGHLAN: Thank you, Doctor. Dr Vine.

9

10 PROFESSOR VINE: Firstly, I think it's a really important
11 area to keep looking at and to keep trying to understand.
12 I think that we shouldn't sort of clump all of this
13 together because I think there are at times - there might
14 be different aspects, if you like: it might be language, it
15 might be religion, it might be a lot of other social
16 determinants like comorbid substance use, family
17 disruption, and I think it's also pertinent to remember
18 that some of these same issues relate to not access to
19 treatment as compulsory patients but access as to
20 healthcare, both mental and physical healthcare, and we
21 need to sort of remember that that aspect to good
22 healthcare is a really critical element for the broader
23 population of people with mental illness quite apart from
24 this particular subgroup.

25

26 So it's not new, people have been looking at the
27 influence of migration and ethnicity and other aspects on
28 presentation to mental health services for many decades,
29 but clearly what we shouldn't have is anything that is
30 easily amenable to be one of those barriers. So, it
31 shouldn't be that there's late presentation, it shouldn't
32 be that language is not taken into account and interpreted
33 as an appropriately cultural - culturally appropriate
34 environments are not there and some of those are present,
35 but I think there is a broader issue here as well.

36

37 MS COGHLAN: Thank you, Dr Vine. Mr Carroll, would you
38 like to comment?

39

40 MR CARROLL: I can't add greatly to what the other
41 panellists have mentioned on this particular topic.

42

43 MS COGHLAN: Thank you. Can we move on now to the next
44 topic which is oversight mechanisms. Mr Carroll, perhaps
45 if I could direct this to you first of all and ask you this
46 question: what are the purposes of oversight?

47

1 MR CARROLL: I suppose at its most basic or essential,
2 it's about having - to my mind it's about having proactive
3 measures in place to ensure that what is intended - that
4 what's occurring, in this case in the field of mental
5 health, is what is intended to be happening, and I suppose
6 there are a number of dimensions that go towards defining
7 what it is that's intended to be happening, and at the bare
8 minimum three dimensions to that.

9
10 The quality of treatment, and that's all treatment,
11 not simply compulsory treatment but treatment per se, the
12 extent of reliance on compulsory treatment, and also, the
13 legality of compulsory treatment. I do think it's
14 important to distinguish between the two of those because,
15 as our oversight mechanisms currently operate, assessing
16 the legality is quite rightly very much an individual
17 assessment of the person, their circumstances against the
18 particular criteria, which is quite distinct and very
19 separate from the broader sort of population based question
20 of the extent to which we rely on it and the place that it
21 has in the overall service provision.

22
23 As I said, I think core to that is that, whatever the
24 oversight mechanisms are, there needs to be both that
25 combination of them being responsive but also proactive.
26 We can't be reliant on those who are within or affected by
27 the system to be the ones who drive or initiate the
28 oversight processes, the processes themselves need to be
29 operating and keeping abreast of things without relying on
30 individuals to be the agents for attention on a particular
31 issue.

32
33 MS COGLAN: Mr Carroll, what would you say then about the
34 processes for ongoing monitoring or checking that things
35 are working properly?

36
37 MR CARROLL: Look, perhaps a little alarmingly, I drew a
38 bit of a blank - not so much of a blank there, but I
39 suppose perhaps the most fundamental question to be asking
40 is, how did we end up where we are now? Why is a Royal
41 Commission process necessary and arguably very overdue?
42 How did we get here and was it detected earlier and there
43 was just no way that the issues were meaningfully raised or
44 given the attention that they required, or were things
45 simply occurring out of our field of vision?

46
47 So, in terms of thinking about what oversight is

1 needed for the future, I mean, the Royal Commission is
2 going to provide its recommendations and roadmap for what
3 our mental health system of the future needs to look like
4 and how it will also need to evolve, and we obviously need
5 to have mechanisms in place or a combination of mechanisms
6 to ensure that in 10, 20, 25 years' time, we're not looking
7 back on a failure to realise the objectives and the goals
8 that will be reflected in the Commission's recommendations.
9

10 As to the nuts and bolts and the particulars of how
11 that might be achieved, I'm certainly interested to hear
12 other people's more specific ideas.
13

14 MS COGHLAN: Thank you Mr Carroll. Dr Maylea, would you
15 like to comment next?
16

17 DR MAYLEA: I think this is, I think, in quite a lot of
18 detail in my submission I think. To refute a key point
19 though, that the oversight system, that I think in my
20 submission I objected to the way that Mr Carroll
21 (indistinct) that there's an issue with uptake as if it's
22 the responsibility of the people in the system to uptake
23 these oversight services themselves and I think that's
24 highly problematic. We really need to make sure that the
25 system polices itself in a way that's guided by the people
26 using the system rather than expecting people who are using
27 the system to do the oversight.
28

29 And in particular, referring back to the previous
30 question, people who don't trust systems or don't trust
31 oversight capacity or haven't had previous experiences,
32 such as many First Nation people and many new Australians
33 are going to find these oversight mechanisms much less
34 effective.
35

36 I think immediately the easiest thing to do would be
37 to ensure there's universal access to legal representation
38 at the tribunal, I think that's essential so that people
39 understand that, and then you have somebody else subbed in
40 there to engage those oversight mechanisms, I think that's
41 really important, and universal access to non-legal
42 advocacy.
43

44 I take Professor Brophy's point before that we need to
45 really highlight those human rights protections within the
46 oversight system.
47

1 And finally, and I've been saying this for a long
2 time, our oversight mechanisms are not robust enough,
3 they're far too conciliatory. There are very few attempts
4 to take services to task in the way that dissatisfied
5 consumers and survivors would like to see those services
6 taken into account, and there is a widespread - VMIAC have
7 done a number of surveys and consultation mechanisms to
8 engage with people's experiences of oversight and human
9 rights protection, and there's widespread dissatisfaction
10 with the current regime.

11
12 And so, yeah, my submission is that we need to
13 completely revise the oversight mechanisms, reinforce them,
14 be much more rigorous, much more consistent, much more
15 driven by consumer experience, and so that means consumers
16 need to be in charge of them, not just a seat at the table,
17 it is control of the table, and so, I think there's a lot
18 of work to be done there before we have oversight
19 mechanisms that are worthy of the name.

20
21 MS COGLAN: Thank you, doctor. Professor Brophy, would
22 you like to comment?

23
24 PROFESSOR BROPHY: Yeah, look, I think one of the
25 challenges here is really about - I think I'm building on
26 what Mr Carroll was saying about, how do we have good
27 oversight in relation to quality of care?

28
29 It's one of the frustrations I think of the tribunal
30 that it's not appropriate at this point in time for the
31 tribunal to direct what needs to happen in the context of
32 seeing someone move towards a less restrictive option, but
33 there needs to be some oversight of enabling good quality
34 care that is focused on human rights and is focused on
35 appropriately moving people off treatment orders.

36
37 But how that's actually realised in practice, I think,
38 is actually very difficult because I think we've all seen
39 examples of where a lot of data is actually being
40 collected, and there's been in many ways what looks like
41 accountability mechanisms being put into place, but they
42 don't end up proving to be meaningful or actually drive
43 change.

44
45 So I think my comment about this is really that people
46 need to be engaged with actually research and data
47 collection that's meaningful for them, and that includes

1 consumers and carers, and that people are active
2 participants in those oversight mechanisms in one way or
3 another, and actively participating in responding to what
4 is found, so that people are actually involved in an
5 iterative process that, as I said, is meaningful to them.

6
7 MS COGLAN: Thank you, Professor. Dr Vine.

8
9 PROFESSOR VINE: Thank you. In any of this there's a sort
10 of hierarchy of needs, isn't there. There's no point in
11 having oversight mechanisms if what they're overseeing is,
12 you know, a few crusts on the table. They can flog the
13 system all they like, but the system can't produce what the
14 oversight mechanism is trying to monitor unless it has the
15 wherewithal and the capability to do that.

16
17 So I do think that consideration of oversight needs to
18 also think about, is it just there again as a means to an
19 end of itself, or is it there to promote service quality,
20 and that means there has to be the capability to provide
21 that quality, and I agree with what Professor Brophy said.

22
23 I think having an independent external board or
24 tribunal has actually been fantastic. It came in in the
25 1986 Act. It wasn't welcomed by clinicians at the
26 beginning, but I think most clinicians now would see it as
27 absolutely a fundamental part of providing treatment and a
28 fundamental part of their role to justify that. Now, how
29 they do it could be a lot better, you know, the whole sort
30 of therapeutic jurisprudence sort of thing, but nonetheless
31 they do it. But I think that has to be balanced against
32 that oversight being such a burden on services that in fact
33 they're constrained and their ability to provide what
34 they're meant to provide is damaged.

35
36 I think, if we come back to what we were talking about
37 before, some of the culture and quality of the
38 relationship. The whole thing about psychiatry or mental
39 health services is about engagement between people, and the
40 workforce needs to feel valued by the system within which
41 it works, so the oversight has to be tempered to be
42 meaningful oversight that's not just an administrative
43 process, it's not just a flogging process, it's something
44 that has meaning for all the participants.

45
46 I don't have a problem with legal representation. I
47 would comment that I think legal representation happens

1 when you've got a really good service system and really
2 skilled empathic staff that are providing the service. I
3 think you need to be - I know it's not an either/or, but I
4 think it needs to be very carefully balanced.
5

6 Also, just to touch on this point: oversight is really
7 important. Professor Brophy mentioned before about the
8 sort of invisibility of this group of people who receive
9 mental health services, and it's a striking invisibility
10 because it barely exists in mental health plans. If we go
11 right back to mental health matters or even before that,
12 the people who are not mentioned and the clinical services
13 who barely get a mention are really this group.
14

15 And so, that says something else about how that
16 oversight should be, there also should be a visibility
17 about that oversight, and I think a greater awareness and
18 transparency and a greater inclusion. I think the tribunal
19 puts out great reports but I don't know how many people
20 read them. You know, the annual report's a great report,
21 but it has not tended to include a lot of emphasis on this.
22

23 So I think there are various layers of oversight. I
24 think it has to be congruent with what is able to be
25 expected from a service so that it is meaningful and it's
26 not just a burden rather than a benefit or a protection,
27 and I think the workforce needs to be able to understand
28 that that oversight is not there to criticise them or blame
29 them, it is there to help them do their work.
30

31 MS COGHLAN: Thank you. Would a panel member like to
32 comment further on that? Yes, Mr Carroll.
33

34 MR CARROLL: Certainly, and I think I might jump ahead to
35 one of your points in the list, Ms Coghlan.
36

37 Professor Vine is absolutely right to point out that
38 oversight mechanisms should not be an administrative burden
39 as such, and that's certainly something that the tribunal
40 is cognisant of and it's certainly something we turn our
41 minds to. And, we acknowledge that there's aspects of our
42 current procedures or practices that can certainly improve
43 in this regard and we're undertaking work in relation to
44 that.
45

46 Because the feedback isn't only from clinicians that
47 some of the - for instance, the reports that are prepared

1 for hearings are burdensome to prepare; the feedback from
2 consumers is that they're burdensome to read, so we're not
3 hitting the mark there and we have to improve and we're
4 doing a lot of work there.

5
6 But I do think we also need to challenge or push back
7 at points and develop an appreciation that accountability
8 can actually be fundamentally linked to quality of care.
9 It's not an add-on, it's not the, ah, we've got to do this
10 at the end of the month or we've got to do this now; it
11 should be a feature of regular and constant service
12 provision.

13
14 As I said, we acknowledge that, as we currently
15 require, reports to be prepared for hearings is not
16 satisfactory, but at the same time what we require for
17 hearings can be boiled down to having a very clear picture
18 provided about who the person is, their current situation,
19 the treatment that's being provided to them, the why it is
20 that a treating team has reached the view that the criteria
21 for an order is met, what's planned for the future and in
22 particular what's planned to get to a point where an order
23 is no longer required.

24
25 Now, that shouldn't be something that's just brought
26 together and collated for the purposes of the tribunal, it
27 should be there and readily accessible in relation to a
28 person at any time because it should be informing quality
29 care provision to that individual consumer.

30
31 The other thing - and again, Professor Vine touched on
32 this - often the former board and to a lesser extent but
33 still to some extent the tribunal will encounter a mindset
34 of, oh god, the time we spend on tribunal hearings is time
35 not spent treating clients.

36
37 Now, we work to a model where our hearings run for up
38 to an hour, and what we have done as a tribunal is adopt a
39 framework, a practice of solution-focused hearings. We've
40 done that for a number of reasons, but one of the reasons
41 is that we want to conduct hearings which aren't just about
42 talking to the tribunal, but are providing a relevant and
43 important opportunity for treating teams and consumers and
44 carers to speak to each other with the tribunal involved in
45 that discussion as well.

46
47 So that, if we're all engaging with the process

1 appropriately and constructively, we're not talking about
2 oversight which is this loss of an hour that could be used
3 for so many better things, but rather, a relevant and
4 useful hour that can be used to start perhaps addressing
5 some issues that are in conflict and laying out a clearer
6 plan for the future.

7
8 MS COGHLAN: Dr Vine, did you want to respond to that at
9 all?

10
11 PROFESSOR VINE: Look, I absolutely agree, and I wasn't
12 meaning to say that the current tribunal was an unnecessary
13 burden; I didn't wish to extend my answer, but remember
14 that at the moment the oversight mechanisms include the
15 Mental Health Complaints Commission, the Independent Mental
16 Health Advocacy, Community Visitors, Second Psychiatric
17 Opinion Service and the tribunal, and I probably left out
18 something. So, the tribunal, I sit on the tribunal, I love
19 it, I think we do a really good job, I'm not disputing what
20 Mr Carroll said at all.

21
22 MR CARROLL: And, Ruth, I wasn't jumping down on anything
23 you said either, the principles you refer to are absolutely
24 sound.

25
26 MS COGHLAN: Mr Carroll, just before we move on from that,
27 and Professor Brophy you might also have a comment on this.

28
29 At the moment the tribunal doesn't have, as I
30 understand it, a role in the ongoing treatment plan or
31 preparation of that, is that something that you'd like to
32 comment on, Mr Carroll?

33
34 MR CARROLL: It's the source of constant confusion for a
35 whole range of people, including tribunal members, and
36 clinicians, consumers, carers: what is the tribunal's role
37 in relation to treatment?

38
39 And, of course, the tribunal does not make decisions
40 about individual treatments, but we are very clear about
41 the fact that, even though we know that there are
42 boundaries around our role and we're not a treatment
43 decision-maker, we certainly do have a role in relation to
44 treatment issues, and we've done quite a bit of internal
45 work reflecting on this and endeavoured to develop
46 materials that explain that for others as well.

1 Back under the former Act, the 1986 Act, there were
2 amendments - I forget when they were implemented - which
3 required the then Mental Health Review Board to review a
4 treatment plan as part of any hearing that it conducted in
5 relation to an involuntary patient. The role of the board
6 was to check whether the authorised psychiatrist had
7 considered particular things that were set down in the Act
8 in developing a treatment plan, and to assess whether or
9 not the treatment plan could be implemented.

10
11 Now, I can assure you, you could meet the requirements
12 of what was set down in the Act, you could come up with a
13 treatment plan that was able to be implemented, but what
14 you had was entirely deficient as a meaningful treatment
15 plan for an individual. This was a statutory mechanism
16 that introduced an incredible amount of process and
17 paperwork that was fundamentally focused on producing a
18 document for the Mental Health Review Board rather than
19 producing a meaningful collaborative treatment plan between
20 consumers, carers and the person's treating team.

21
22 So, I don't think anyone mourns the absence of a
23 similar mechanism in the present Act, but because the
24 tribunal in contrast to the previous board has - if it
25 makes a treatment order, it is required to determine the
26 duration of that order. We're very clear that we can
27 only - we're making a determination about duration that is
28 responsive to the individual circumstances, so the
29 timeframes that are set down in the Act are statutory
30 maximums rather than default durations for treatment
31 orders, and in relation to that we need to understand
32 what's happening and what's proposed in relation to
33 treatment to be able to meet/reach a meaningful decision
34 about how long a treatment order should run for.

35
36 Some of the things that we do explore - based on that
37 approach to our statutory function around duration the sort
38 of things that we see ourselves as having treatment issues
39 that we have a role in relation to - and in doing this as
40 constructively and as carefully as possible - but exploring
41 points of disagreement around treatment and how they might
42 be resolved, or what the strategy is to try and reach a
43 more satisfactory arrangement at some point in the future.

44
45 Exploring apparent gaps in treatment; I mean, a lot of
46 the discussion today has rightly been about - well, a lot
47 of the discussion today is about wanting to minimise, quite

1 rightly, compulsory treatment. There's a group of
2 consumers who attend tribunal hearings and talk - their
3 concern isn't about the fact that they're on a treatment
4 order, but that they want further supports that they aren't
5 actually receiving. And, whether it's related to the
6 order or not, there are needs that they want met, so we
7 explore gaps in treatment.

8
9 We want to look at there being at least the beginning
10 of shared responsibilities for getting to voluntary
11 treatment. So, voluntary treatment isn't about, we'll take
12 away the order when the person does what we tell them to,
13 it's something far more nuanced and negotiated than that.

14
15 We want to explore side-effects and consumers'
16 experiences of side-effects associated with their
17 treatment. And also, I can think of no more a
18 sophisticated way to put this, but some of the things that
19 just don't make sense. You sometimes observe things
20 happening in relation to a person's treatment, and the
21 cases that come to mind in particular are some people who
22 are in highly restrictive environments such as SECUs, and
23 the rationale for what's happening at a given time
24 sometimes evades everyone and can't actually be clarified
25 in the course of a hearing. So, as a tribunal making these
26 orders and as a public authority under the Charter, we
27 can't just turn a blind eye to these things, we have to
28 explore and understand and try and, not just develop our
29 own understanding, but enable the consumer, the carers and
30 everyone involved have a better understanding of what's
31 going on.

32
33 The other thing at a very mundane level is about
34 fostering discussions that are free - fostering discussions
35 in hearings that are free of jargons and acronyms, because
36 people can read their report for a Mental Health Tribunal
37 hearing and be none the wiser as to who is who and who's
38 doing what, because everyone's described by reference to
39 these impenetrable acronyms, some of which are statewide,
40 some of which are local, and just obscure meaning for
41 everyone.

42
43 MS COGHLAN: Thank you, Mr Carroll. Professor Brophy, did
44 you want to comment on that?

45
46 PROFESSOR BROPHY: I just want to agree with everything
47 that Mr Carroll just said, and I hope I haven't been

1 misleading in sort of implying that the tribunal doesn't
2 have a role in relation to treatment, I think he set that
3 out really well what the role is.

4
5 I think what I wanted to add to this discussion is
6 that, whatever oversight mechanisms we do have around
7 quality of care, they have to have clout, there has to be a
8 way to be able to influence.

9
10 I think again on the tribunal there may be examples of
11 where people, for example, get stuck, they get stuck in a
12 SECU. We've had some really positive things to say about
13 Forensicare, they're well deserved, but there has also been
14 examples of people getting stuck there as well in
15 Forensicare in a context of other service providers
16 refusing to consider taking a referral, or negotiating the
17 possibility of that person being able to move to a less
18 restrictive option, even though it's in many ways perfectly
19 appropriate.

20
21 And, without an oversight mechanism with the clout
22 that can enable services to collaborate, work together, and
23 really genuinely work towards enabling that person to get
24 the quality of care they deserve, then I think it's very
25 difficult.

26
27 So, I don't have the answer to where they get that
28 clout from, but I think they need it.

29
30 MS COGLAN: Thank you, Professor. We might come back to
31 that question in relation to people being stuck a bit
32 later, and particularly in the context of long-running
33 orders or those that are continued frequently.

34
35 Can we just move on at the moment to safeguards, and I
36 can direct this, please, to Dr Maylea, and you've also
37 already touched on this in the context of the oversight
38 mechanisms.

39
40 All of the panel members refer to ways in which the
41 uptake of safeguards could be improved, including things
42 like education and advocacy. What I'd like to ask though
43 is, other than the existing safeguards, what other
44 mechanisms could be considered to protect the rights and
45 dignity of people living with mental illness?

46
47 DR MAYLEA: So, just on the existing mechanisms to begin

1 with, the use of mechanisms needs to be much more robust,
2 for example in regard to advance statements. My research
3 and other people's research has shown that they're treated
4 with often disdain by clinical services. There's some
5 evidence that in the tribunal setting they're used as
6 evidence, that people are - you know, if there's odd things
7 or, you know, I've had situations where the person has said
8 in their advance statement they're not going to take the
9 medication and then the tribunal don't believe them on the
10 day when they say they are going to take the medication.
11 So, the way that they're currently used is not really
12 operating effectively.
13

14 The Second Psychiatric Opinion Service uses the same -
15 you know, draws from the same pool of doctors as the public
16 system does, and then draws on the same notes that those
17 same pool of doctors have used in their treatment and
18 assessment decision, so those safeguards are nowhere near
19 as effective as they should be.
20

21 I'll point to - I don't think there's been any
22 research done on it, but in theory there's an example in
23 the ACT where an advance statement, if the treating team
24 don't want to follow the advance statement, which I think
25 in that context is about a directive, the actual client
26 equivalent of the tribunal they had to overwrite the
27 advance statement. So, there are some very simple things
28 we could be doing to really reinforce the system that we've
29 got. There is a big problem certainly with the lack of
30 availability of safeguards in a timely manner.
31

32 So, the number of people who are admitted on the
33 weekend and then released on Monday as soon as the IMHA
34 advocate is called, because there's just no oversight on
35 the weekend, there's almost nothing there in terms of - and
36 if you want a tribunal hearing it might be weeks; if you
37 want access to an advocate, it might be days; second
38 opinions can take weeks and weeks. So, they're very
39 ineffective, I would say, in terms of doing what they're
40 intended to do currently and a lot of that is to do with
41 resourcing.
42

43 More broadly, I think again, while involuntary
44 treatment is available to be used, it just will be used and
45 abused. One thing that could be addressed in the England
46 and Wales Act, there's a requirement that anyone who is
47 exercising powers undergoes training before they're legally

1 able to exercise powers.

2

3

4 I mean, the number of clinicians who have no formal
5 training in the Act is phenomenal, and no concept of
6 anything other than the treatment criteria, certainly no
7 in-depth understanding of the principles or of the kind of
8 broader - you know, I think Matthew spoke to us before
9 about helping people understand what to do differently.
10 But, you know, the lack of supported decision-making
11 training, the lack of recovery oriented practice training,
12 all these sorts of things. So, there's a range of options
13 there.

13

14

15 But ultimately, people experience coercion as harmful.
16 It doesn't matter how many safeguards there are, it's
17 stigmatising and traumatising and dehumanising, and so,
18 yes, we should be trying harder to reduce that harm, but no
19 amount of safeguarding is going to take away the harm that
20 the coercion causes, and nothing's really going to repair
21 the therapeutic relationship once it's been so badly
22 damaged by recourse to compulsory treatment.

22

23

24 So, I think it's kind of the wrong question in terms
25 of how can we improve this, it's still going to involve
26 holding somebody down and sticking a needle into them at
27 the end of the day, and so, no amount of safeguarding is
28 going to reduce that harm.

28

29

MS COGHLAN: Thank you. Dr Vine.

30

31

32 PROFESSOR VINE: Well, of course, you know, the first
33 thing I'd have to say is that clinicians do not hold
34 someone down and inject them with a drug because they're
35 cruel, malicious or arbitrary. There is an indication, and
36 I regret that sometimes that's the treatment that is
37 required because other treatments like working with the
38 person, or oral or whatever, have not been sufficient.

38

39

40 So, I just think it's really, really important to keep
41 reminding ourselves that this is a publicly funded health
42 system within all of the governance and oversight and
43 expectation that goes with a health system, and that the
44 people who work in it - not universally, I won't say that
45 because some people just go there for a job and don't go
46 there because they've got a real desire to help people -
47 but mostly the people who work in that system do not enjoy
restrictive interventions and do not complain about the

1 oversights that serve to scrutinise them.

2

3 It makes me sad to hear commentary that makes it sound
4 as if there's not a reason why those sorts of intrusive
5 interventions are undertaken.

6

7 Anyway, having said that, so look, again, I think
8 oversight is incredibly important and I certainly agree
9 with Dr Maylea that clinicians, anyone who is empowered or
10 authorised to act under the Act should understand the
11 objectives, the principles, the history of that
12 legislation, its limitations and its intentions, and so,
13 making sure people are well informed and know how to
14 explain that I think is really important.

15

16 But I do come back to some of the things that we said
17 earlier, that if people could present earlier to nicer
18 places, with better continuity of care, with all of those
19 things, then some - not all - but some of that oversight
20 would be less critical and the people who were doing that
21 oversight wouldn't express such concern about what they
22 saw, so I think the balance needs to be there.

23

24 MS COGLAN: Thank you, Dr Vine. Professor Brophy.

25

26 PROFESSOR BROPHY: Yeah, look, I've got - I just want to
27 throw in support for training. I think we have really good
28 examples of people benefitting from recovery-orientated
29 practice training and supported decision-making training,
30 including psychiatrists.

31

32 There was some great work done in psychiatry around
33 supported decision-making training that people really
34 appreciated, and I can't help but think that we have
35 neglected for, I think since the mid-1990s, to really train
36 people well in what the new expectations of their role were
37 going to be in relation to having so many people on
38 Community Treatment Orders. We have never really had good
39 training that's actually focused on that issue, and that
40 ties in with the expectation of the Act and it ties into
41 assisting people to work towards less restrictive
42 interventions.

43

44 I think the other thing though is that, if we're
45 talking about safeguards that I think are very fundamental
46 that we still don't give enough credit to, we've all talked
47 about continuity of care, but I have to reiterate that

1 continuity of care also represents a safeguard for people,
2 and we don't value continuity of care. We have an
3 incredible tolerance for the churn in our system, and we
4 don't do enough to try and stop that from happening. You
5 know, whether it's rotation of registrars, whether it's
6 just the siloed nature of teams that mean that people are
7 moving from one service delivery environment to another
8 without that continuity; I think this is a fundamental
9 safeguard that we persistently neglect and I would say that
10 it's really important for us to get back to basics there.

11
12 The other thing is that, I've mentioned some micro
13 injustices that I think we really, really need to rethink.
14 The idea of people on Community Treatment Orders having to
15 pay for medication is appalling in my opinion, and it
16 wasn't always the case, it's kind of crept in. And, it's
17 also not universal. So, we have people who have
18 exceptions, we have some people who are doing it, some
19 people who don't. And even though we might say it's a very
20 small amount of money, it's extraordinary that someone
21 who's on an involuntary order, a compulsory order, doesn't
22 want to take that tablet or have that injection, is then
23 required to pay for it. I just can't see how we can
24 justify it

25
26 Similarly, I cannot see how we can justify that person
27 also paying for the car parking at the hospitals, at the
28 service, or paying for the public transport to even get
29 there. These are just things that we just tolerate and we
30 don't even sometimes see the impact that it might be having
31 on that person, so I think we need to really rethink a lot
32 of some fundamentals about what we're doing and recognise
33 that they are actually important, that's an important
34 safeguard in the mechanism itself.

35
36 MS COGLAN: Can I just pick up on what you've said there,
37 Professor Brophy, about getting back to basics when it
38 comes to continuity of care. Can you just expand on that,
39 what is it that you think needs to be done?

40
41 PROFESSOR BROPHY: I think it comes to the idea that we
42 need to recognise that practising mental health relies on
43 relationships and relationship building. I think it's
44 about moving away from a biomedical perspective and the
45 dominance of pharmaceutical interventions and actually
46 recognising that to do good work in mental health we have
47 to have good relationships between staff and consumers,

1 staff and carers and other supporters, and we need to work
2 on those relationships over time, and they're not going to
3 magically happen.

4
5 We've talked a lot about kindness and compassion, but
6 often that's not enough; it's not enough to just be kind
7 and compassionate. We actually have to be able to reflect
8 on the work, we have to think about what's happening, think
9 about the dynamics that are emerging between people
10 involved in a situation and carefully work through the
11 challenges around those relationships. And, if we don't
12 have people doing that over a longer period of time, if
13 people don't have time to build that kind of trust and
14 build the skills that they require, then we're paying lip
15 service to the idea that relationships are important in
16 mental health.

17
18 So, I really have a problem with this because
19 sometimes I think we do need specialist roles, we need
20 people who can take - who may be are involved in a
21 situation in the short term and that actually is important,
22 but I think even when we have that we still need to have
23 that sort of fundamental of having that continuity.

24
25 And, like I said, I think we just tolerate the churn,
26 and sometimes we build the churn, we make it happen. We
27 have people who move from one position to another in the
28 very same team, and they have to leave their caseload
29 behind to go and take up the caseload that belongs to the
30 other position: that's a very different way of thinking
31 about what the purpose of that person's role is just in
32 that particular set of decisions. It denies all of what's
33 been important in terms of that person building a
34 relationship with the people that they're case managing or
35 that they're treating as the treating doctor.

36
37 So, I hope that doesn't sound too preachy but I think
38 it's really essential for us to be rethinking it.

39
40 MS COGHLAN: Thank you, Professor. Can I move - yes,
41 sorry, Dr Vine.

42
43 PROFESSOR VINE: I just want to say: absolutely agree, no
44 argument.

45
46 MS COGHLAN: Thank you, Dr Vine. Mr Carroll, can I raise
47 the question with you about, other than existing

1 safeguards, what other mechanisms could be considered.
2 Now, that might not be a question you directly want to
3 respond to, but do you have something to say about this
4 topic?

5

6 MR CARROLL: Thank you. The particular things I was going
7 to mention, Ms Coghlan, are things that you've flagged that
8 you're coming to anyway: it was around the safeguards for
9 stuck individuals and long-term rolling compulsory orders.

10

11 MS COGHLAN: Thank you, Mr Carroll. We're actually doing
12 well for time, surprisingly, but we'll get to that shortly.
13 I was hoping to move on to the last topic now, which is
14 service provision at discharge.

15

16 It's convenient in a way that we get to this last
17 because every one of you has spoken about quality of care
18 as an essential feature throughout this discussion. What I
19 wanted to do was just to recite for you really briefly what
20 the Commission heard from a consumer last year in relation
21 to their experience and then just ask you to comment on it
22 and directed to this question of quality of care.

23

24 The Commission heard this:

25

26 *When you're a compulsory patient you're*
27 *staring at the walls, there's nothing to*
28 *do, no therapy, no programs. There was a*
29 *broken piano and a few broken crayons,*
30 *everyone's contained in one small space.*
31 *The only so-called treatment was ECT and*
32 *drugging and you only saw a psychiatrist*
33 *every few days.*

34

35 So that's what one consumer relayed to the Commission
36 last year. So, in the context of that being the experience
37 of that person and many others that the Commission has
38 heard about, what are the key elements that underpin
39 quality of care during the course of compulsory treatment?
40 And perhaps I could direct that to you, Professor Brophy.

41

42 PROFESSOR BROPHY: Well, I think one of the things that
43 I've tried to encourage people to think about here is the
44 idea of reciprocity. You know, if you're in a situation
45 where you've been empowered to take away someone's autonomy
46 and their human rights, and you think that's necessary,
47 then a fundamental justification of that is that you give

1 back, that you provide supports and services that in some
2 way justify that initial action.

3
4 And I think that case example that you've given,
5 Ms Coghlan, is a really good example of how we struggle to
6 achieve that level of reciprocity. You know, because I
7 don't think that person is gaining anywhere near the
8 benefit of what we've already established are incredibly
9 expensive services to run, and yet, well really, why
10 wouldn't you run away?

11
12 It's extraordinary that people can be so bored, and
13 have so little intervention during the time that they're on
14 the inpatient unit, or feel like they have anyway, and then
15 that can also then translate to what happens when they're
16 back out into the community.

17
18 I think it goes back to our safeguarding, our issues
19 around quality of care, that we have a situation where that
20 is not tolerated.

21
22 MS COGHLAN: Dr Maylea, would you like to comment next.

23
24 DR MAYLEA: I think that the service system we have now is
25 almost an inevitable consequence of not having to provide
26 services that people want. If we have a situation where
27 people want to walk away rather than doing all the work to
28 engage people in services, we can just put them on an
29 order, this is what we end up with, is services that people
30 don't want to go to. And so, it's no surprise that that's
31 people's experiences I think when they're in places like
32 that.

33
34 There's no incentive for the services or for the staff
35 in the services - and I absolutely agree with Dr Vine that
36 people do get into these roles for all the right reasons,
37 but you know, the number of inpatient units around the
38 states that have common rooms or art rooms that are locked
39 all of the time because the services are too scared to let
40 people in them is phenomenal.

41
42 So, of course, until the services are run for and by
43 the people who are using them, or until people are free to
44 leave services that they find unpleasant, we're going to
45 have no incentive to provide the quality of care that's
46 required, and that is inherently bound up in this problem
47 of being able to rely on compulsory treatment.

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MS COGLAN: Dr Vine, can I ask you, would you like to comment on that?

PROFESSOR VINE: And I would like to comment on that. Firstly, let's just remember that we're talking about a state-funded service system. Your example was of an inpatient unit, I don't know whether it was a long stay or an intensive care area, but whatever, it's an inpatient unit that's probably funded at about 50 per cent of its actual cost.

So, services have an agreement with Government through their Statement of Priorities about meeting certain budgetary requirements, so I think it's really, again, really important that those services - to the best of my knowledge they're not off buying holiday homes with the money, they're delivering what they can within the funding provided, and in many cases they're actually taking services away from the community services in order to bolster up their inpatient services, so that's the first thing.

I think the second thing I'd say is, that's a hideous description, and nobody should be in an environment like that whether they're well or unwell, you know, whether they're as disturbed as all, get out: it's just heartbreaking, isn't it.

The other thing about that is, that environment is not going to be conducive to the person's level of distress or disturbance being less, it's not going to be conducive to staff engagement because there's nothing with which to engage.

I mean, staff engage around activities, they engage around, they don't - people get sick of talking just to a staff member on just that, but they might as well engage around a particular activity, or a particular functionality, like cooking or artwork or whatever it might be, so that just speaks to the poorness, the poverty of the units.

Alongside that there's the other thing that I think Dr Maylea mentioned, which is, sometimes those environments have been progressively denuded in response to coronal recommendations about, oh, you can't have a kettle because

1 it's got hot water, and you can't have an electric cord,
2 and you can't have a curtain and you can't have a pencil
3 because someone's going to swallow it. Of course that's
4 true, all of those things have happened, but they happen to
5 a very small number of people, and yet, the ramifications
6 are to everybody in the service, and that comes back to
7 that balance between putting in place more person-oriented
8 restrictions if you need to, like maybe one-on-one
9 specialing rather than removing pencils from the entire 25
10 inpatients. You know, the one person who might be at risk
11 of swallowing the pencil maybe could be more closely
12 supported or supervised or distracted rather than nobody
13 having any pencils.

14
15 I think we have had this sort of layered response in
16 two directions: one has been to remove the sorts of
17 amenities that very rarely are taken to be - because of,
18 you know, of risk of danger or risk of causing harm, so
19 we've denuded the environment on the one hand, and on the
20 other hand we've also reduced the funding that would enable
21 services, and that's not just provided by staff, but also
22 even volunteers, even volunteers can do things, they still
23 have to have things to do, as well as the whole range of
24 peer support workers or Allied Health and others, and I
25 think it's pretty sad because I think, particularly
26 sometimes where we see that level, is sometimes even in the
27 places where people spend the longest.

28
29 I can bring to mind one of the country's SECUs that's
30 a very deprived environment, and yet, people are there
31 for months. So, it's horrible and it shouldn't be, and
32 somehow we've allowed it to be, except you know, here you
33 are, so that's good.

34
35 MS COGHLAN: Can I pose this question to you, Dr Vine, in
36 the context of what you've said: if resourcing is not an
37 issue, if the environment is the kind of environment that
38 engenders people feeling safe and comfortable, what does
39 the quality of care look like for that person to then, in
40 the course of being an inpatient for example, to be treated
41 well?

42
43 PROFESSOR VINE: So, I mean, look, in part the core part
44 of being treated well - and look, I learnt this when I was
45 working in prisons - is to treat - to treat is the wrong
46 word - to interact with a person with respect and dignity
47 and common human politeness, you know, that gets you off to

1 a good start.

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But I think we are talking about a therapeutic environment, so quality of care is the relationship, but it's also what is provided within that relationship. Professor Brophy highlighted the ability to reflect and to - there will be times during a person's day when they are far more accessible, if you like, and amenable to talking about things that will explore how they came to be in this situation and how - what might need to change to reduce the likelihood of it happening: how to build up a person's resilience, their coping skills, their understanding of their triggers and, in a dull way, their understanding of the drug they're on.

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I actually agree with Professor Brophy, the pharmacological treatment, it might be the backbone, but it's just that, it's not the flesh, it's not the body of treatment of an intervention. So, the quality of care, I think, is the range of interventions that are applicable and appropriate for that person and, to the extent that we can do that, are chosen by that person.

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There will always be limits to that. You can maybe go to Peter Mac and request a massage, but you probably can't go to Peter Mac and request cardiac surgery because that's not what they do, so there will always be some limits of what is relevant in that environment, but I think the quality of care is: what is provided, how it's provided and the environment in which it's provided.

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And so, while I'm on this little roll, the other challenge for service providers at the moment is, what we gained with local accessibility by having small units in, you know, 21 areas across the state, what we gained with that we lost with being able to respond to a whole range of needs. If Commissioner Armitage talked to Sandy Jeffs about Larundel, she'd probably also highlighted that at Larundel you could have art therapy and religious therapy and you could go for a walk and you had the acute ward and the less acute ward and, you know, there was a whole range of options available both to the person receiving the care, but also to those providing the care, and that has been very constrained with this smaller more locally accessible but one size fits all sort of unit.

47

MS COGLAN: Thank you, Doctor. Can I move on to you,

1 Mr Carroll, and particularly get to this question about
2 people being on orders for a long period of time, or
3 whether they're renewed or continued.

4
5 You have a particular view on that with patients who
6 are stuck and who can't seem to shift from say a SECU or
7 some other kind of secure environment.

8
9 MR CARROLL: Thank you. And look, the two are often
10 intertwined in the one person situation but at the same
11 time the issues can be quite distinct as well.

12
13 So, the notion of the stuck individual was one that
14 the tribunal described in its first submission to the
15 Commission. So, it's generally people in a highly
16 restricted environment such as a SECU or people at Thomas
17 Embling who were originally security patients but whose
18 term of imprisonment has concluded and they were
19 immediately placed on a treatment order, so are continuing
20 as a compulsory patient.

21
22 From the tribunal's observations what is often a
23 complicating factor in working out next steps for these
24 people and steps to a less restrictive environment is
25 that - and sometimes treating teams will be being very -
26 and everyone will be in furious agreement, that the
27 manifestations or the symptoms of a person's illness are
28 relatively well managed at the time that we're conducting a
29 hearing, but finding next steps will often require
30 collaboration or cooperation across entirely different
31 health services, and this is especially the case for people
32 in Thomas Embling where, where they want to go, Forensicare
33 provides a service that's located at Thomas Embling; where
34 they go is going to bring them under the care of an
35 entirely different mental health service, and getting
36 cooperation and collaboration around that can be incredibly
37 difficult.

38
39 And, the tribunal has observed particular cases where
40 the imperative didn't actually seem to be to find a way to
41 support the person's progress, but to do whatever was
42 possible to avoid being the service that took this person
43 on next and then had responsibility for them.

44
45 So, these are issues that a tribunal hearing can
46 certainly shine a light on and require a degree of
47 accountability for, but at the end of the day they can

1 rarely resolve because - not to sound that we ever approach
2 these matters prejudged - but it's not necessarily whether
3 the criteria are met that's the key question in issue here,
4 but what is going to happen next for the person, and the
5 tribunal has no role in directing, okay, this person needs
6 to move on from here and to have that happen this service
7 is going to have to do this.

8
9 In my witness statement I referred to this again, but
10 also was quite up-front that we weren't necessarily
11 suggesting that it should be the tribunal that does that, I
12 think that question requires a lot more exploration as to
13 what entity or what authority is the one that can step in
14 when collaboration or progress is just halted and things
15 need to be moved on.

16
17 The other group that we've referred to, or the way the
18 Act is currently structured, and in the vast majority of
19 matters it's entirely appropriate, is that, each hearing
20 for an individual is treated as a self-contained or a
21 discrete event. But what that does mean for someone who's
22 been on a series of consecutive orders, is that, there's an
23 approach to whether or not to make the fifth Community
24 Treatment Order; that's pretty much indistinguishable from
25 the approach as to whether or not to make the first
26 treatment order when a person had had 28 days worth of
27 compulsory treatment under a temporary treatment order,
28 whereas this person might be facing their fifth year on a
29 Community Treatment Order.

30
31 The tribunal has endeavoured to bring more rigor and
32 process to these matters, so we do - we identify matters to
33 be for intensive case management, our resources to do this
34 are somewhat limited, whereby we have continuity of
35 divisions as far as possible in conducting hearings for
36 these individuals.

37
38 We don't have a power to make directions as that term
39 is normally understood, but we certainly make requests and
40 seek further information to be provided for a next hearing,
41 or we openly flag issues that are troubling or that need
42 further information.

43
44 We do at times try to join other services as parties
45 to a hearing. Now, sometimes these things do have a degree
46 of traction and can contribute to process. Other times,
47 there are times where our letters won't even be answered,

1 to be completely open and blunt, and so, thought needs to
2 be given - and I know there's a degree of arbitrariness as
3 to, when do you say somebody's been on too many treatment
4 orders and there needs to be more rigor attached to the
5 process to decide - a more complex process applied to
6 deciding whether or not to make another one, but there is
7 this group of people who I think the Act should put in
8 place a slightly different, or perhaps very different,
9 approach to how we look at the question of what's to happen
10 next in terms of further treatment orders for them.

11
12 MS COGHLAN: Thank you, Mr Carroll. Moving on from that
13 specific topic, I'd like to just focus on discharge and
14 particularly the context of discharge from inpatient
15 setting.

16
17 Perhaps if I could direct this to you, Professor
18 Brophy. Considering how to best support people upon
19 discharge in a way where they're informed and empowered:
20 can you comment on that?

21
22 PROFESSOR BROPHY: Well, I think what we need to do is
23 recognise that when people are being discharged from
24 hospital, in some ways that represents a very challenging
25 time for people, it's a point of transition. So, even
26 though at one level it's a recognition that maybe they're
27 doing well, transitions have their own problems attached,
28 so actually being able to provide service delivery that
29 acknowledges that this person is in the process of a
30 transition and actually supporting that transition
31 appropriately by - and, you know, as Dr Maylea said, doing
32 what we can to enable people to have a voice about that,
33 about what they need, what's going to be helpful for them,
34 and then actually structure services around that.

35
36 You know, I was reading Dr Vine's statement, and I'm
37 aware that, you know, it can be incredibly expensive to
38 have services that are available 24/7 to people in this
39 kind of context, but hopefully what we can do is enable
40 services to concertina up and down, if you like,
41 appropriately for particular people and have that kind of
42 flexibility, and recognising that that flexibility is
43 actually what's often required when people are in these
44 times of transition. It may be that, again, it's the range
45 of different possibilities of service, and we know that
46 some people have actually benefitted greatly from having
47 peer support workers taking up the role of post-discharge

1 support.

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This is where I think sometimes mental health service providers forget that practical support is actually a core component of what they do, and we shouldn't underestimate the value of providing people with practical support, and it sits with giving people information and all of that, but actually being able to be with people and provide them with practical support may be incredibly important in this kind of circumstance. I hope I'm getting to the point of your question.

MS COGHLAN: Thank you, yes; yes, you are, Professor. Can I move on to Dr Maylea.

DR MAYLEA: I think, yeah, I'm coming full circle back to the first point that I made today. The idea of transitions or of discharge, it's completely conceived around the idea of how we deliver services, and completely the reason that we have ended up where we are is because we have forgotten about how services are received.

There shouldn't be a transition, there shouldn't be a discharge; people should have the same support irrespective of the setting they're in. I mean, how we've ended up in this space is quite bizarre actually, and I think it's just because we just borrowed the model from the physical health system into mental health.

And so, yeah, I think, if people were in charge of their own service delivery or choose who they wanted to work with and then they would work with those people and we wouldn't have this big panic around transition plans. I mean, it's just - if people wanted to transition or have a different team then, you know, that can be facilitated for them.

But we've ended up with, we're trying to fix this broken service system and we're forgetting that the problem is with the way we've organised the service systems rather than something that, you know, we can add an extra program or extra protocol. So, call it - let's not call it discharge, let's call it transition, yeah, that'll fix it. We really need to be thinking about providing a different way of providing services to address all of this.

MS COGHLAN: Thank you, Doctor. Dr Vine.

1
2 PROFESSOR VINE: So, just to pick up Dr Maylea's final
3 point: it's actually not that mental health is copying
4 physical health in this, it's actually physical health is
5 copying mental health with greater emphasis on hospital in
6 the home and health in the home, which Victoria put in
7 place with the frameworks documents in 1995 and 1996.

8
9 I think it's important that - discharge planning has
10 always been an important component of good care, and
11 discharge planning often meant involvement with the CAT
12 team pre discharge, and early discharge planning with the
13 CAT team and then, you know, much more intensive work. So,
14 I do think, and I know this is very dull to keep saying the
15 same thing, but I do think that the problem, some of the
16 problems we have with discharge at the moment are to do
17 with there being such a gap between inpatient and community
18 and what can be provided.

19
20 And again, if I went back to when I was a younger
21 psychiatrist, we even had CAT respite houses, there were
22 places where people could sort of stay for a few nights in
23 the community as part of a transition, or even just, you
24 know, when things were bubbling up in their lives.

25
26 I think too, and I do think services have become
27 hardened to this, and they've sort of had to become
28 hardened to this because, you know, we all have to develop
29 protection, but at the moment there's no doubt that we
30 discharge into totally unsuitable places for discharge,
31 quite apart from the level of care that's available, and we
32 do it knowingly, but we do it inevitably because of that
33 whole problem of throughput and flow.

34
35 And I think that, you know, difficult things happen to
36 clinicians when they have to make those decisions, they do
37 become hardened, and we discharge people into places that
38 clinicians would refuse to visit because of levels of risk.
39 Again, to say that is pretty brutal, isn't it, and it's of
40 course not universal but it is real.

41
42 The other thing I'd highlight here is that, perhaps
43 more than most other sort of populations of health
44 recipients, people who have received care as compulsory
45 patients may be more likely to have unstable social
46 situations, may be more likely to have fractured family
47 relationships and unstable accommodation, so they actually

1 have added burdens around discharge that we haven't given
2 due regard to. Unfortunately, I think the solutions to
3 that are partly around workforce, but also partly around
4 model of care options and also about actual places, places
5 to provide accommodation and the sort of supports.
6

7 I just also - I think discharge from places like, most
8 often, secured extended care and most often Thomas Embling,
9 that discharge of planning is much more protracted, often
10 really well considered. People coming out of Thomas
11 Embling have often had day leave and accommodation and work
12 leave for months, so their transition is a much more
13 gradual one. Again, one of the difficulties we have in the
14 acute system at the moment is, discharge is often
15 precipitate, poorly planned, poorly supported, you haven't
16 met the person beforehand, and that just adds to that
17 problem of transition as others have commented.
18

19 MS COGHLAN: Thank you, Dr Vine. Mr Carroll.
20

21 MR CARROLL: I won't add to what's already been covered by
22 the others, thank you.
23

24 MS COGHLAN: Thank you. Is there any other further
25 comments that panel members would like to make? We're
26 about to conclude my role in this proceeding, I'll hand
27 over to the Chair shortly, but is there anything else that
28 anyone else would like to add at this stage before the
29 Commissioners have an opportunity to ask you questions?
30

31 PROFESSOR BROPHY: Could I just follow up what Dr Vine
32 said about housing and people's opportunity for safe and
33 secure housing, and how - I'm sorry that I hadn't even
34 mentioned it up until then and I'm so grateful that she had
35 mentioned it, because I think it's something so central to
36 the discussion that we've been having; that while we have
37 situations that so many of the people that we are
38 supporting struggle to get safe and affordable housing, it
39 creates enormous problems as well, and limits people's
40 opportunities I think for choice and control about
41 treatment and service delivery because they just don't have
42 that safe base and I think it's a really, really dreadful
43 situation for all of us.
44

45 MS COGHLAN: Thank you very much, Professor. On that
46 note, I'll hand over to our Chair to direct the discussion
47 with Commissioners asking the panel questions.

1
2 CHAIR: Thank you very much Georgina, and thank you very
3 much panel members for the fabulous discussion we've just
4 had; I think it's been incredibly helpful, both through the
5 discussion and your witness statements, for us to think
6 about the future design of a mental health system in
7 Victoria that improves the quality of care and outcomes for
8 those living with mental illness, so I think it's a very
9 important contextual discussion for us.

10
11 There's one issue I don't think that we've addressed
12 to my satisfaction and I just want to make sure I have an
13 understanding of the panel members' position on this. We
14 also have as Commissioners imperatives to take into
15 consideration the commitment there is to address the
16 unacceptable rate of suicide in the Victorian community,
17 and also to think about what role the mental health system
18 has to play in promoting community safety, so two different
19 issues that we have to take account of.

20
21 If I go back to Dr Vine's witness statement, in
22 paragraph 105 she says amongst other things:

23
24 *It is impossible to predict suicide and*
25 *other adverse events.*

26
27 But she also goes on to acknowledge earlier in her
28 statement, and I'll just use it by way of example because
29 it's illustrative of the point we've got to grapple with as
30 Commissioners, and this is paragraph 13:

31
32 *Members of the general public do not like*
33 *seeing a person in distress and in general*
34 *find that a person who is mentally unwell*
35 *and acting strangely frightening. Random*
36 *acts of apparent senseless violence are*
37 *most often related to untreated mental*
38 *illness.*

39
40 Just by way of using those two comments to help
41 underscore the importance of this issue and how the
42 Commissioners might grapple with it, can I ask the panel,
43 are you urging us to not take false comfort in the role
44 that compulsory assessment and compulsory treatment can
45 play in the achievement of the imperative about reducing
46 the suicide rate and also promoting community safety?
47

1 So maybe Dr Vine, given I asked you and quoted a bit
2 from your statement, do you want to start? I know it's a
3 difficult one but it is a really important issue that we
4 need to grapple with as a Commission.
5

6 PROFESSOR VINE: Yes, thank you, Commissioner, and I'll
7 try not to go on for too long. To take your first
8 point which is about the difficulty of prediction, and
9 Dr Maylea's touched on this and I think Mr Carroll did as
10 well, there are reams, reams of literature written about
11 the factors that are associated with suicide and, you know,
12 sometimes it feels like every group is at some level at
13 risk and, you know, we've got young men, old men, single
14 women, child and adolescents, blah, blah, blah, we could go
15 forever. They are all population-based risks.
16

17 To work out the individual in front of you at that
18 moment who might make a decision to intentionally take
19 their own life is much harder. Having said that, there is
20 a very clear association between some mental illnesses
21 and - particularly of course severe depression and
22 particularly severe psychotic depression - with intentional
23 death, with suicide. So, I think there is an element of
24 compulsory care which is about taking away from a person
25 their choice, their responsibility for their safety, and
26 imposing a treatment that will mitigate that particular
27 risk. And I think there's lots of evidence for that. It's
28 hard to predict which particular person with psychotic
29 depression, or which particular person with a borderline
30 personality disorder who is in the throes of a crisis will
31 jump in front of a train, but still those people are at
32 absolutely heightened risk and there is something we can
33 do, and sometimes we can do that without compulsory
34 treatment and sometimes we need compulsory treatment. One
35 of the roles of compulsory treatment is in relation to
36 absolutely significant harm.
37

38 The other one, prediction of harm to others, is I
39 think even more problematic, but again, any clinician will,
40 particularly perhaps in the domestic situation, any
41 clinician would say, whoa, I'm really frightened for this.
42 Let's just use an example of a mother and children. A
43 mother with a post-partum psychotic illness who has got
44 real fears that her baby is not her own or that her baby is
45 not going to - that she'll be a bad mother, or real fears
46 that some other disaster is going to be visited upon them.
47 That's a predictable risk of immediate harm to another and

1 sometimes, again, compulsory care will avert that risk, and
2 so, I think that's a really important thing.

3

4 The third example which I gave in my witness
5 statement, and I think the reason I did that was because
6 there'd just been a random act of senseless violence, I
7 think it was just after that incident where there'd been
8 two people stabbed on a railway station and another
9 bystander stabbed in Hawthorn. I can read that in the
10 paper and I can think to myself, wow, the chances are that
11 that person has an untreated psychotic illness because why
12 else would a person do that unless they felt pursued and in
13 danger, why else would someone do that? Or else, you know,
14 if we see some of the mass violence acts from
15 North America, often associated with a degree of grandiose
16 delusional belief, and again, a sense of both victimisation
17 and empowerment.

18

19 So again, terribly hard for that to predict, but not
20 impossible to try and predict. I think Professor Mullen
21 has done very good research on this in terms of the
22 association between increased risk particularly of serious
23 offending and mental illness and, if you take an untreated
24 mental illness it ups it by particularly - you know, by a
25 factor of 10 or something, and if you add in alcohol and
26 substance abuse it ups it by another 20. So, it's not
27 perfect for the individual, but it would be foolish to say
28 it didn't give us a guide, and so, I hope that answers your
29 question a bit.

30

31 CHAIR: It does, thank you. Dr Maylea, do you want to
32 make a comment in relation to that and then I'll come to
33 the other two panel members as well.

34

35 DR MAYLEA: Yes. I think I will separate out the question
36 about how comfortable the community feels when someone is
37 in distress, I think I'll separate that out from the harm
38 aspects because I think that's really problematic and I
39 think that a lot of community expectation stuff is around
40 unbased fear rather than legitimate sense of harm to self.

41

42 I live in the west of Melbourne, I will often see, in
43 Sunshine and Footscray, people crossing the road to avoid
44 groups of young black men who are, you know, just existing
45 in the street. Now, from my observation it looks like
46 they're afraid of those young black men standing on the
47 side of the road, and thankfully in this country we only

1 rarely detain young black men because white people are
2 scared of them, and I think there's a direct correlation
3 here between racial discrimination and fear of the other,
4 and discrimination against somebody on the basis of,
5 they're talking to themselves or being dishevelled or
6 having unusual ideas that exist from that person's reality.
7 So, I think on discrimination grounds we should immediately
8 reject any pandering to that bigotry in society, because
9 it's disability discrimination, it's unlawful, and so, the
10 fact that somebody is behaving (indistinct) should have no
11 relevance to compulsory treatment.

12
13 Coming to, you know, obviously - and this is
14 particularly raw for me at the moment in terms of having
15 recently lost a friend, a good friend and a colleague, the
16 suicide rate in Victoria is unacceptable. We already have
17 compulsory treatment in Victoria and it does not lower the
18 suicide rate. There is no - I mean, only - even if we
19 detained everybody who we identified as having one of those
20 static risks - I mean, as Dr Vine pointed out, we wouldn't
21 have very many people left in society - and we still
22 couldn't prevent it. People still are successfully
23 suiciding in inpatient units, it just doesn't work.

24
25 Setting aside the risk prediction issue, it's just, we
26 know what works: engaging with people, linking them into
27 the community, addressing those core issues; medication is,
28 for a lot of people, a really big part of that.

29
30 Consistently when we talk about reducing compulsory
31 treatment there's this idea that, oh, we're going to end up
32 with people who die: people are already dying and the
33 system we have isn't preventing that. We need to shift
34 away from that.

35
36 There are few things I think more damaging to the
37 essential relationship which does prevent suicide or does
38 reduce the risk of suicide of positive therapeutic
39 relationships with people with supports and people who are
40 thinking those kinds of thoughts than compulsory treatment.
41 If that connection, that access to that service, a
42 significant number of people - and we don't have any data
43 on this, this is very difficult to assess, but I don't
44 think it will be contested - but a significant number of
45 people whose suicides could have been prevented through
46 good therapeutic intervention suicided, didn't get that
47 support, because they were afraid of being involuntarily

1 treated if they reached out for support from their mental
2 health services.

3

4 I think it's very problematic. We know that there are
5 ways at a population level to reduce suicide risk, and
6 they're addressing inequality and you know, a whole range
7 of things that we are all well assisted by the evidence.

8

9 Coming then to harm to others: all those other
10 arguments still stand, I think, but ultimately we can't
11 discriminate against people on the basis of their
12 disability. I just want to touch on - Dr Vine mentioned a
13 few times that it depends if you accept the model of mental
14 illness, and I think it's a bit more nuanced than that,
15 because you can accept that people experience distress and
16 experience hallucinations or voices or any other range of
17 symptoms without buying into the model, the medical model
18 of categorising that illness in some way, or replacing the
19 person's experience for that as a clinician. I want to
20 just kind of reinforce that I'm not suggesting that people
21 with distressful experiences aren't real, just that
22 medicalising a response to that is - well, some people find
23 problematic.

24

25 So yeah, I think that sums it up. It is really hard
26 in response to harm to others as we have been consistently
27 seeing. Despite having the highest levels of involuntary
28 treatment in the state, we don't have the lowest levels of
29 violence to others or the lowest levels of suicide - sorry,
30 not in the state, in the country. So, at a population
31 level I don't know what clearer evidence to point to than
32 that. The solution is in providing good quality services
33 that people want to use when they want them and that will
34 allow them to access those services.

35

36 CHAIR: So, Professor Brophy, thank you.

37

38 PROFESSOR BROPHY: Yes, look, I've got a couple of things
39 to say about this. I have appreciated Michael Marmot's
40 kind of description of depths of despair, and I do wonder
41 whether the Commission needs to also start engaging with
42 this. What we're talking about is often, yes, it may be
43 people who have had a diagnosis of a mental illness, but
44 suicide also reaches out to people who use drugs and
45 alcohol, are marginalised, are affected by inequality, and
46 when we see rates of inequality increasing in our
47 community, then that's probably what we're really up

1 against if we really want to start thinking about
2 prevention of suicide.

3
4 So often I think we take it down to a level of
5 individual practitioners and individual people, and we
6 think about the challenges associated with compulsory
7 treatment in that context, when overall we're facing this
8 broader societal challenge.

9
10 We haven't talked at all about the integration of drug
11 and alcohol treatment actually today, and I'm going to take
12 the opportunity to say that, that we probably should have
13 because we did talk about it quite a lot when we met last
14 week, and we need to acknowledge that drugs and alcohol
15 have a role to play here as well and, you know, the
16 potential for people to accidentally overdose, that kind of
17 thing, or that drugs and alcohol contribute to feelings of
18 despair, and I think these are the kinds of things that I
19 think we need to engage with.

20
21 As well as, what do we do about the problem about the
22 inaccuracy of risk assessment, when we do want to try and
23 prevent people from suiciding? I think we are all touched
24 by it in one way or another and wishing that perhaps we'd
25 done something in those kinds of situations, but maybe we
26 need to think more broadly about protections for everyone,
27 not just trying to single out particular people, and that
28 we think about, you know, things like people not having
29 access to guns and other kind of lethal means and those
30 kind of things are actually really important, and for us to
31 be very aware that any one of the people that we're working
32 with might choose to intentionally take their life when it
33 could have been avoided.

34
35 If we think about how we can build up our awareness
36 about that without doing it necessarily in a way that
37 represents placing a whole lot of restrictions on people,
38 but actually more focuses very strongly on how to build up
39 the protective factors around suicide prevention, whether
40 it's for individuals all the way through to the community.

41
42 I think the other thing is that we have to look at the
43 very scary findings that Matthew Large and his colleagues
44 have found, which is that, the high rates of suicide for
45 people who actually come out of hospital, so come out of
46 the very hospitals that we've put them in to try and
47 protect them, where sometimes they also die as well, sadly,

1 but then we see this spike in people who suicide after
2 coming out of hospital. That is a very important and
3 telling thing.

4
5 Now, there's all sorts of reasons for why that might
6 happen: maybe it's about people being discharged too soon,
7 and so all the efforts that, as Dr Vine has talked about,
8 about people wanting to try and achieve about trying to
9 prevent someone from harming themselves haven't had the
10 time to be realised. There's also the possibility though
11 that the actual trauma of going to hospital and everything
12 that people have experienced, and that terrible story of
13 sitting around in a place where there's only one broken
14 pencil, you know, has actually had an impact and is
15 actually contributing to that idea of the depths of despair
16 and that we are part of it, which is terrible.

17
18 So, in other words, I don't have an easy answer for
19 you, Commissioner, but I think there's more to this than
20 what happens between an individual clinician trying to
21 predict whether someone is going to suicide; it has to be
22 thought about in this much broader context.

23
24 CHAIR: Thank you. And, Mr Carroll, before I go to
25 Professor McSherry for her question.

26
27 MR CARROLL: Thank you, Commissioner. Look, one of the
28 numerous reasons I mentioned earlier in the morning about
29 really being opposed to "risk" being a term used in the
30 criteria for compulsory treatment; a further reason why I
31 dislike that term there is I think it creates a
32 misconception that when it comes to tribunal hearings what
33 we're doing is looking at capital R, capital A, Risk
34 Assessments in relation to suicidality or harm to others,
35 and that simply isn't the case.

36
37 I think it would surprise, perhaps surprise people how
38 - I'm not in a position to quantify it - but suicidality is
39 not a common feature of discussions in the course of
40 tribunal hearings. The vast majority of matters when it
41 comes to looking at that second criterion about prevention
42 of harm, the focus is on preventing a serious deterioration
43 in a person's mental health, and so again, we don't get
44 into diagnostic labels, we look at the clusters or the
45 bundles of symptoms that the Act directs us to, and the
46 vast majority of matters are determined with a focus on
47 mental health.

1
2 That being said, if there's pattern of past and
3 especially recent conduct that does endanger a person's own
4 life, that will be discussed, and there may be a separate
5 conclusion that the treatment order is also needed to
6 prevent serious harm to them.
7

8 I find that, I think I can say confidently, that in
9 general divisions of the tribunal will seek to avoid a
10 focus on risk of harm to others unless it's absolutely
11 essential in a particular situation, because it's a
12 distressing discussion, it's a stigmatising conclusion to
13 reach, and it's one where there's usually a dearth of
14 evidence to support the view that there's a risk of harm to
15 others because it's often multiplied, hearsay, or things
16 that are so far from the past they can't be really
17 understood accurately or relied upon.
18

19 So, in that context I suppose what I'm saying is that,
20 at the point at which we're conducting hearings, that
21 preventing suicide and preventing harm to others is not a
22 very frequent focus of the reasons that are being put
23 forward by treatment teams for the making of treatment
24 orders.
25

26 I suppose the life-saving scenarios, for want of a
27 better label, that we're most frequently required to engage
28 with are in the context of ECT applications concerning a
29 person who has psychotic depression and has stopped eating
30 and drinking, and also the very small number of matters we
31 conduct each year concerning generally young women but not
32 exclusively with a diagnosis of anorexia nervosa.
33

34 CHAIR: Thank you very much. So, Professor McSherry, I
35 know you'll have some questions before Dr Cockram and then
36 Professor Fels.
37

38 COMMISSIONER McSHERRY: Yes, I'd also like to thank all
39 the panellists for wonderful statements and I'm just so
40 pleased to see that there's quite a bit of consensus
41 between you all, which is great, so that gives us something
42 to work with.
43

44 I have several questions, but I'll try to confine
45 myself just to two. The first one - or they both concern
46 the legal framework for compulsory treatment.
47

1 The first question is to Mr Carroll. I'm interested
2 in your statement about the objects and principles in the
3 current Act but unfortunately they sit within an Act that
4 enables compulsory treatment.

5
6 We know that there are other statutes in Australia
7 that actually govern voluntary treatment as well as
8 compulsory treatment. So, I'm wondering whether you're
9 saying we should look to a legal framework across the board
10 in relation to that.

11
12 And the other part to that is that, we know in, I
13 think it's in the Northern Territory, that there is an
14 avenue where a person has a right to appeal a refusal of
15 treatment.

16
17 We know that economic, social, cultural rights are
18 very difficult to legislate, placing obligations on the
19 state to provide access to treatment is very difficult to
20 legislate, but is that something that we should be
21 considering?

22
23 MR CARROLL: I'm not sufficiently familiar with the other
24 frameworks you've referred to, Commissioner, to answer too
25 fully here.

26
27 Perhaps to go to the second point first, I think the
28 one Victorian precedent I'm aware of for a statutory
29 framework that allowed for an application to an independent
30 body around a refusal to treat was under the old
31 Intellectually Disabled Persons' Services Act, where a
32 person who was declined service by - who is assessed as not
33 meeting the eligibility criteria under that Act to receive
34 support, and I suppose what we would now call a support
35 package through intellectual disability services could make
36 an application to the Intellectual Disability Review Panel.

37
38 The panel's powers were purely recommendatory, the
39 legislation didn't go so far as to give the panel an
40 authority to say, right, this shouldn't be happening, this
41 person should be receiving support: it made
42 recommendations.

43
44 As having been a member of that panel for a number
45 of years prior to it being disbanded, it was a very
46 fraught - it wasn't used - well, the panel was never used
47 extensively in relation to anything, but when it was in

1 relation to eligibility it wasn't particularly effective.

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2 COMMISSIONER McSHERRY: Yes, I think this is more for
3 clarification to Dr Maylea. Under our Terms of Reference
4 we have to come up with practical recommendations. You've
5 mentioned that we really should be working towards the
6 elimination of compulsory treatment.

7
8 So, do I take it that you mean, if there was no mental
9 health legislation, if it were abolished tomorrow, what
10 would prevent clinicians relying on their discretion and
11 common law powers of necessity to treat people? Are you
12 saying we should be working towards this or is this
13 something that we could put in place providing there was a
14 lot of support for people? So, you know, how realistic is
15 it that mental health frameworks or legal frameworks could
16 be abolished now as opposed to, you know, working towards
17 it in 10 years' time or so on?

18
19 DR MAYLEA: Thank you. Certainly, there are - in the same
20 way that the institutionalisation failed to maintain
21 supports that were necessary for the people, and that
22 allowed people to criticise institutionalisation because in
23 so many ways asylums provided supports that were really
24 necessary for people. And so, I would be very - I would
25 very strongly support the abolition of involuntary
26 treatments to be done in the context, the immediate
27 context, of providing all those other necessary supports
28 and the fundings that are there.

29
30 If I had to choose, I'd say yes, we probably - if the
31 option was, do we do it now or in 10 years? If we say
32 we're gonna do it in 10 years, we're probably never gonna
33 do it. So yeah, I'd say do it now and let's make the
34 services work out how to engage with people in the way that
35 they want to.

36
37 You know, there is absolutely a requirement that we
38 then engage with the prison system to make sure that people
39 don't end up there instead, you know, there are a range of
40 other reforms that would need to accompany it. But, yes, I
41 would say that realistically the work needs to be done,
42 that the transition pains, the discharge from involuntary
43 treatment pain needs to occur, and so, yeah, we can do it
44 now.

45
46 I know that, you know, in terms of a risk of having a
47 counter to that, Dr Vine, you will have a counter to that.

1 Yeah, I think about this a lot. The opportunity is now,
2 and so, now is the time to take that opportunity.

3

4 CHAIR: I did notice, Dr Vine, you do want to say
5 something. I'm conscious of time, so a quick comment from
6 you before we go to Dr Cochrane.

7

8 PROFESSOR VINE: A really quick comment. By and large
9 the urgent treatments that you referred to, Professor
10 McSherry, happen when a person is brought to hospital,
11 usually comatose or following a trauma. By and large the
12 disturbance created by mental illness occurs in the
13 community, so what you would have is a lot of people being
14 disturbed in the community who inevitably go down a Justice
15 pathway, not a health pathway and, if you think that's a
16 good idea then, you know, I think you'd need to think of
17 the ramifications. Thank you.

18

19 CHAIR: Thank you. Dr Cockram.

20

21 COMMISSIONER COCKRAM: My question is for Mr Carroll.
22 There appears to be consensus on the panel about reducing
23 compulsory treatment with Dr Maylea, as he's just
24 expressed, wanting to pursue elimination. But also there's
25 consensus about the need for significant improvement in the
26 quality and options of care and support, and balancing this
27 with some of the important discussions we've had about
28 choice and human rights.

29

30 So, my question follows on from your discussion around
31 the lack of risk-free options, as you called them, and your
32 experience in relation to carers', community views and, as
33 we've said, the system leader views which is not always, as
34 might be hoped, a no blame culture.

35

36 How might we change the discourse? What would be your
37 suggestions for changing the discourse within the system
38 and within the community to allow for greater choice and
39 allow for greater understanding about the implications of
40 that choice in, you know, in the coming period?

41

42 MR CARROLL: Goodness. In terms of changing broader
43 attitudes, when I mentioned that notion of risk fluency and
44 developing risk fluency, it was drawn on work that was
45 drawn from a former tribunal member and also former Chief
46 Psychiatrist, Dr Sally Wilkins, who reflected quite a bit
47 on - and I'm paraphrasing her words here - but there's

1 arguably a fundamental lack of honesty with the community
2 about what can be done in terms of risk assessment and what
3 can be done in terms of risk prevention, and that becomes
4 especially pronounced at times when greater - when the
5 honesty is most needed.

6
7 So when things - even if we take an entirely coercive
8 or punitive approach to issues, things do go wrong. And
9 there's never - and in response to the headlines of, how
10 could this be allowed to happen, which so commonly it's
11 phrased, "It's been allowed to happen, someone has made a
12 mistake", there's no real testing of that with the
13 community and there is this sense of, if we create more
14 laws, or if we create more restrictive laws, we'll be able
15 to prevent it ever happening again.

16
17 Now, this isn't to, of course, suggest that when
18 things go wrong we should just say, oh, wasn't that a
19 shame. But we learn from things and, when we reflect on
20 them not with the expectation that people will have the
21 gift of prophecy, but whether or not they've taken all
22 reasonable steps that they can to explore a situation,
23 understand the options, and put in place what appears to be
24 the best response to a given situation at that time.

25
26 It may down the track not have the outcome that was
27 hoped for, but not predicting that outcome is not a flaw or
28 a failing of the person who made a decision, and this
29 arises in the context of tribunal hearings as well: we
30 might be being encouraged to make less risk-averse
31 decisions than we do. We do so knowing that there's no
32 certainty about what will happen subsequently, so there is
33 that need to develop honesty and fluency in the community
34 around risk, so that then we just don't have this knee-jerk
35 reaction to situations of always looking for the order, or
36 the law, or the restriction that's going to prevent things
37 going wrong in the future - that's guaranteed to prevent
38 things going wrong in the future.

39
40 COMMISSIONER McSHERRY: I don't know if any of the other
41 panel members have any thoughts about how we can improve
42 that discussion of honesty that allows then greater choice
43 in the system from an external perspective?

44
45 I don't know, Dr Maylea, if you've got any views on
46 that but it seems this is an important aspect for us to
47 consider.

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DR MAYLEA: Yes, it is tricky, and I think one of the reasons that governments ask Royal Commissions to look into these sorts of things is because there may be decisions and recommendations made that are politically unpopular or that are inconsistent with public opinion and public expectations, and I think this is probably just one of those things where, you know, the experts concur that we can't predict risk; the shock jocks have no idea what they're talking about and we probably should ignore them.

And so, yeah, I think it's a really brave decision to have to make, but I think that's the one that needs to happen. I think we need to set aside misguided public expectations and just be really clear on the messaging, I think. That'd be how I would respond to it. Obviously, I don't have to make that decision, but yeah.

CHAIR: Dr Vine, do you want to say something before we go to Professor Fels?

PROFESSOR VINE: I know we're really, really short of time. We've commented a couple of times during this morning about the invincibility of this, and the sad thing I think is that there is a bit of a reason for that, and we sort of know that, unless public debate is very, very, very carefully managed, then in fact what is stimulated is the fear and loathing response, not the care and compassion response.

Victoria has a post sentencing authority now, it has a growing little community out there at Ararat of people who have done their - served their time and still we can't sort of get them back into the community, so I think we need to be cautious.

Unfortunately, the counter-media, the counter-media of the dangerous mentally unwell person, is enormously emotionally powerful and resonates, unfortunately, with many, many people in the community, and we see the reaction when someone escapes from Thomas Embling, you know, that's just out there. We saw Derryn Hinch and, you know, just - I've lived through some pretty hideous interviews about that.

So, I agree we need to find a way, but I would caution in thinking that it's easy because I don't think it is.

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CHAIR: Thank you. Professor Fels, have you got a question you'd like to ask?

COMMISSIONER FELS: Yeah. Just, could we have a few brief comments on what should be the role of families and carers in this? And, what is the actual role, does it match the best? Maybe of Matthew Carroll.

CHAIR: I notice that, Dr Vine, you'd like to comment too. So, Mr Carroll.

MR CARROLL: There are just some brief observations I'd offer in relation to the role of carers, and one of the principles of the Act speaks to the need to involve carers as far as possible in decision making and in treatment planning, and I forget the particular provision in this Act, but there were some adjustments made to confidentiality provisions that were intended to allow services to share a little more information with family and carers than was permitted under the former Act.

The tribunal is required to notify carers - a carer on the record of any upcoming hearings in relation to the person that they care for, and that's how we - that's what triggers our engagement with carers, and in relation to that I'd note that, despite what the Act envisaged about better - continuous and sort of normalised involvement of carers in matters wherever possible, it doesn't happen as effectively as hoped.

Just on a very pragmatic point, we rely on the information retained by service - gathered by services so that we can notify carers of upcoming hearings. We often can't fulfil our statutory obligation because the data isn't up-to-date or complete, and so, we fail at the outset of involving them in our processes. We're one of the last steps in the process that needs to be notifying them of things so, if we're not satisfactorily notifying them of what's happening with the tribunal process, then it appears that they've not been involved at various points before that.

The way in which compulsory treatment, as we've discussed many times this morning, can be seen as a way of ensuring access to treatment means that carers, I think in a number of instances and in a number of hearings, feel

1 pressured to speak against the preferences of the person
2 they care for because, whilst they might be confident that
3 at this present time an order isn't needed, they're
4 concerned about what might happen down the track should the
5 person they care for require more intensive support but not
6 be able to access it as a voluntary patient, and this is
7 usually based on specific - on lived experience, not just
8 conjecture.

9
10 The other conundrum the tribunal encounters in
11 relation to the involvement of carers and families - and,
12 of course, it is complex, it's stating the bleeding obvious
13 that family dynamics are incredibly complex, but there are
14 provisions in the Act that allow for information to be
15 withheld from a patient or a consumer in the lead-up to a
16 tribunal hearing, and that is most commonly relied upon
17 where treating teams have had private or confidential
18 discussions with carers and family.

19
20 Now, the tribunal certainly respects the fact that in
21 some cases this will be absolute, this will be necessary,
22 but we also observe, I suppose, an over-reliance on it,
23 where it's perhaps - and look, we have enormous respect for
24 clinicians and service providers, but it seems that often
25 it's just that little bit easier to say, let's have a
26 confidential discussion and we'll keep it off the record
27 and it won't be heard by anywhere else, than going through
28 the more difficult and complex process of enabling those
29 discussions to happen in the open and happening with
30 everyone.

31
32 So, they're the particular things I'd raise in
33 relation to carers, acknowledging that the tribunal's
34 interaction with carers is very limited and there'd be much
35 broader issues that they'd want flagged.

36
37 CHAIR: Thank you. I guess I'm conscious now of the time,
38 and we are 10 minutes over the commitment that the panel
39 members gave us, but I think it's been an incredibly rich
40 conversation, as I've said earlier, that we've had today.

41
42 We have chosen to have our panel hearings help us to
43 grapple with some of the very difficult issues that we
44 think are there for the future systems design, and can I
45 really thank you all for the effort that you have put into
46 assisting us with that task and, Ms Coghlan, for your
47 leading us through the evidence and the issues that the

1 panel members have raised.

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And so, on behalf of myself and my fellow Commissioners and our team, many of whom are here with us today, I thank you all very much for helping us with this challenging topic and we'll look forward to thinking harder about what else we might need to take into account if we come up with our final position and recommendations.

So, thank you all very much for participating this morning, and now this afternoon, we'll speak again soon no doubt. Thank you.

AT 3.12PM THE COMMISSION ADJOURNED

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