Royal Commission Into Victoria's Mental Health System 2021 - Analysis

A Blueprint For Consumer Control

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Executive Summary

The Royal Commission into Victoria's Mental Health System identified a '*broken'* system that was '*failing to support those who needed it*'. The Volumes and Final Report that resulted from the Commission found that the over-reliance on seclusion, restraint and involuntary treatment is no longer fit for purpose. There is now a need for a paradigm shift to bring practices into line with a recovery-orientated and cooperative model of mental health treatment.

Recommendations 53, 54, 55 and 56 focus on mental health consumer's rights and the elimination of restrictive practices such as compulsory treatment orders (CTOs), seclusion, and restraint. Justice Action believes that these recommendations are essential to a contemporary and more compassionate mental health system that should be responsive to consumer's rights and needs. These recommendations respect, empower and centre around consumers. It recognises the individuality of each consumer case, and the consumer's right to dignified treatment, autonomy of self and treatment. Designed to uphold mental health consumers' human rights and participation, a prime function of these reforms will be the steady reduction and eventual elimination of all 'restrictive' interventions or practices. There is a move towards a more 'collaborative' and 'real person-centred approaches' oriented to 'personal recovery' that will promote alternative interventions and support to better suit consumer needs and choices. The Report claims that real changes will be put in place to shift practices and culture to ensure consumers' human rights are upheld.

The biomedical model, which prefers the views of mental health practitioners over those of consumers, focuses on 'deficits' that need to be fixed by medication, and is molded around a flawed expectation that the system is responsible for managing short-term risk rather than emphasising recovery. The concept of 'personal recovery' needs to be embedded in every level of our mental health system. Consumers are integral to this reform, engaged in its rebirth and forging new pathways of support, acting as stakeholders at every level.

Summary

In February 2019, the Victorian Government recognised the state's mental health system was '*broken'* and '*failing to support those who needed it*'.[1] The Royal Commission into Victoria's Mental Health System, chaired by Penny Armytage AM with Professor Allan Fels AO, Dr Alex Cockram and Professor Bernadette McSheery acting as Commissioners, was formally set up to ensure that '*every person must be able to access a well-resourced, compassionate and responsive mental health and wellbeing system*.'[2]

Over the past two years, the Royal Commission received over 12,500 submissions. The resulting *Final Report* (https://rcvmhs.vic.gov.au/) includes 65 recommendations that set '*out how Victoria's mental health and wellbeing system should be redesigned*.'[3] The overarching theme of the report is that mental health consumers, including individuals with lived experience of mental illness, family members, carers and local communities, are vital to the planning and implementation of mental health treatments and special care. The recommendations aim to empower consumers to control their own industry and resources, ensuring they are an integral part of the redesign of new structures, transition targets, and the re-evaluation of Victoria's mental health system.

The Victorian *Final Report* outlined central challenges to transformation and reform. For example, that the demand for mental health services has overtaken capacity, leading to a crisis driven system that over-relies on medication rather than community-based services.[4] The dominance of a biomedical model has created overwhelming systemic imbalances that lead to consumer's needs not being met, and often, their human rights being breached. This imbalance, and the undersupply of community based services, has generated a significant *'missing middle'* in servicing and support.[5] A consequence of this is the use of seclusion, restraint and compulsion treatment as a primary solution rather than a 'last resort'.

Over-reliance on seclusion, restraint and involuntary treatment is no longer fit for purpose, and now requires a paradigm shift to bring practices into line with a recovery-orientated and cooperative model of mental health treatment, within Victoria's existing 10-year plan timeframe.[6] This involves establishing new and legislated entities to direct and monitor the staged elimination of restrictive interventions and practices. Restructuring the current treatment structure will also ensure that community treatment orders are used only as a *'*last resort*',* where consumers' input and leadership representation will drive the change that the current system had originally intended.

[1] *Royal Commission into Victoria's Mental Health System* (Final Report Summary Plain Language Version, February 2021) Volume 2, page 19.
[2] *Ibid* 2.
[3] *Ibid* 4.
[4] *Ibid* 9.
[5] *Ibid*.
[6] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 3, page 22.

Having heard all major stakeholders and many witnesses' experiences of the entire mental health system, the *Victoria Royal Commission* recommendations have become the driving force for reforms in Victoria and a powerful means of advocacy for other states. The Andrews government's strong leadership and commitment to implementing all of the Royal Commission's recommendations provides a blueprint for other states to follow in improving their own mental health systems.

Four of the Royal Commission into Victoria's Mental Health System's Recommendations are central to this analysis. Recommendations 53, 54, 55 and 56 focus on mental health consumer's rights and what flows from this - the elimination of restrictive practices such as compulsory treatment orders (CTOs), seclusion, and restraint. We believe that these recommendations are essential to a contemporary and more compassionate mental health system that should be responsive to consumer's rights and needs. These recommendations respect, empower and centre around consumers. It recognises the individuality of each consumer case, and the consumer's right to dignified treatment, autonomy of self and treatment.

The Victorian Royal Commission Report found that focusing on consumer rights is pivotal in reforming the current mental health system. To ensure consumer rights are respected - within a non-coercive, 'person-centred' and 'recovery-oriented' approach - the Commission recommended that an independent statutory authority be set up 'to hold the Government to account for the performance, quality and safety of the mental health and wellbeing system.'[7] Within a newly legislated *Mental Health and Wellbeing Act*, a *Mental Health and Wellbeing Commission* is the recommended body to fulfil this purpose and function.[8] The Commission will have a range of duties in promoting *good mental health* and *wellbeing*, including ensuring consumer involvement in the development and evaluation of such services. Consumer representation on the *Safer Care Victoria Council* is one of the ways that consumers have the opportunity to be integral to the regeneration of contemporary mental health systems of health and wellbeing. Within these new and legislated structures, consumer representatives will shape the new procedures of support, and servicing will be commissioned in sustainable ways to respond to the diverse preferences and expectations of people living with mental illness or psychological distress. With consumers engaged to co-create a novel 'architecture of reforms' by participating at all levels, including the commissioning of *'*contemporary and adaptable services*'* [9] and enabling consumer leadership through representation in *Safer Care Victoria*, the oversight and management of reforms is to be phased out over 10 years. Designed to uphold mental health consumer human rights and participation, a prime function of these

[7] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, page 271.
[8] *Royal Commission into Victoria's Mental Health System* (Final Report - Summary and recommendations, February 2021) Volume 4, page 80.
[9] *Royal Commission into Victoria's Mental Health System* (Final Report) Volume 1, page 19.

reforms will be the steady reduction and eventual elimination of all 'restrictive' interventions or practices, including seclusion, (physical and chemical) restraint, and CTOs.

For the individual consumer, their rights are being emphasised in relation to promoting consumer advocacy. The obligation and presumption for service providers is to support consumer's empowerment in making their own decisions regarding mental health and wellbeing management via respecting consumer choice and through non-coercive practices. This includes more 'collaborative' and 'real person-centred approaches' oriented to 'personal recovery' that will promote alternative interventions and support to better suit consumer needs and choices. New legislative basis is expected to have consumer input that will replace the current *Mental Health Act*, and be in line with mental health and wellbeing rather than a focus on illness. The expectation is that by moving towards mental health and wellbeing (not the absence of illness), and reorienting services to support consumer empowerment and adopting non-restrictive practices that emphasise trauma-informed practices and de-escalation methods, individual's 'dignity of risk' will be better respected. In doing so, it is intended that including consumer representation in the oversight of current and new ways of servicing, plus embedding consumer report responses in service provider evaluations, will likely substantially reduce compulsory treatment. This will gradually eliminate restrictive practices such as seclusion and physical restraint over Victoria's next 10 year time frame.

Recommendation 53: Strong oversight of the quality and safety of mental health and wellbeing services.

Recommendation 53 highlights the importance of this body having a 'full suite of oversight functions to monitor, inquire and report on system-wide quality and safety,'[10]. Monitoring as a matter of priority, the use of seclusion and restraint, compulsory treatment, incidences of gender based violence and suicides in healthcare settings.[11]

To further this goal, the Commission recommended the establishment of other bodies and roles to support the *Mental Health and Wellbeing Commission* (Recommendation 44). These include installing new functions/roles of a Chief Officer for *Mental Health and Wellbeing* (Recommendation 45(1)), and *Regional Mental Health and Wellbeing Boards* (Recommendation 4(2)). Also, within the '*Mental Health and Wellbeing Commission*' the Commission recommended that a *Safer Care Commissions* unit is established to:

[10] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, page 89.
[11] *Ibid*.

'*improve quality and safety that embeds contemporary and multidisciplinary approaches in services.*'[12] [The purpose of this unit would be to] *'focus on reducing the use of seclusion, restraint and compulsory treatment ...particularly in inpatient settings.*'[13]

Recommendation 54: Towards the elimination of seclusion and restraint.

This focuses on immediately reducing the use and duration of seclusion and restraint in mental health and wellbeing service delivery, with the aim of eliminating restrictive and compulsory practices within the next 10 years.[14] The Commission identified this recommendation as *'necessary to uphold the rights of consumers and to respond to service failure.*'[15] By respecting consumer's rights and consumer-led reform, the Commission expects that, '*over time, early intervention, less compulsory treatment, well-designed facilities, increased staffing levels and better training and support will remove the need for practices of last resort and establish alternative approaches as routine practice.*'[16] This approach also *'responds to broader concerns that consumers have about human rights issues in clinical mental health environments, leading many to suggest community-based care as a less restrictive option.'*[17]

Recommendation 54 outlines 3 other key steps the Victorian Government should take in order to eliminate seclusion and restraint. First, is the recommendation that the Victorian Government should regulate the use of chemical restraint through legislation provisions in the new *Mental Health Wellbeing Act.* Second, the Victorian Government should ensure the *Chief Officer for Mental Health and Wellbeing* develops and leads a strategy to reduce the use of seclusion and restraint.[18] Third, enable *Safer Care Victoria* to co-design with mental health and wellbeing services, and consumer representatives, targets and recommend strategies to effect staged reforms with the aim of reducing restrictive practices that include compulsory treatment,[19] within Victoria's 10 year plan.

These recommendations are designed to transform Victoria's mental health and wellbeing system so that treatment, care and support are recovery-oriented. This aims to support consumers to build and maintain a self-defined and self-determined meaningful life, regardless of whether symptoms of mental illness are

[12] *Royal Commission into Victoria's Mental Health System* (Final Report Summary Plain Languages, February 2021) 34.
[13] *Ibid.*
[14] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, page 90.
[15] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, page 299-301.
[16] *Ibid*.
[17] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, page 315.
[18] *Ibid* 90.
[19] *Ibid*.

present which is *'consistent with a human rights based approach to non-coercive options provided through community based service offerings.'*[20]

Recommendation 55: Ensuring compulsory treatment is only used as a last resort**.**

Compulsory treatment is the treatment of a person for mental illness subject to an order under the *Mental Health Act* 2014. This can include the compulsory administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. To ensure compulsory treatment is used as a last resort, the Commission recommends that the Victorian Government *'set targets to reduce the use and duration of compulsory treatment on a year-by-year basis*.'[21]

The Commission also recommends that the Victorian Government, *'when commissioning mental health and wellbeing services, set expectations that they will provide non-coercive options for people*,'[22] expanding non-coercive alternatives and improving consumer-centred service. This will also ensure that diverse, well-resourced community-based mental health and wellbeing services are readily available. The Mental Health Improvement Unit within *Safer Care Victoria* is also recommended to work with mental health and wellbeing services to increase consumer empowerment, involvement and autonomy.[23]

Given compulsory treatment's impact on human rights, the negative experience of compulsory treatment experienced by many consumers, and the contested evidence on its effectiveness when used in community settings, the urgency of this reform has not been overstated by the Commission. Compulsory treatment can also have long-term negative effects that range from physical harm, being physically restrained during admission, psychological trauma, severe breaches of human rights, and increased community stigma and discrimination. It is essential that as well as ensuring CTOs are only used as a last resort that treatment, care and support are also provided to people earlier in the community to reduce the need and likelihood of a person experiencing compulsory treatment.[24]

Recommendation 56: Supporting consumers to exercise their rights

Recommendation 56 ensures the promotion and protection of consumer rights through the least restrictive options and increased access to legal representation as part of the mental health system reform. It includes a legislative provision in the new Mental Health and Wellbeing Act enabling an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory

[20] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, page 315.
[21] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, page 91.
[22] *Ibid*.
[23] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 5, page 91.
[24] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 4, page 91.

treatment. In the future, mental health laws are to be aligned with decision-making principles and practices, and to be consumer centred rather than focusing on the clinical paradigm.

This remains a problem in how CTOs, even as a last resort, are to be resolved whilst upholding consumer rights and responsibilities. Dr. Coventry suggested that extended rehabilitation models of care must be altered to better address the potential differences in requirements of people with mental illness and highly complex support needs. Models of care also need to be supported by investment into specialised training and supervision for the workforce. Moreover, a great need to enable the provision of evidence-based treatment for complex needs and intensive psychosocial rehabilitation is a fundamental necessity. Without a streamed approach, consumers with specific needs requiring specialist input are cared for alongside others with differing needs. [25]

Conclusion

Overall, consumer rights are at the forefront of how the system is 're-imagined', to be redesigned. In a contemporary mental health and wellbeing system, consumers' human rights are respected every step of the way and consumers are supported in making decisions that affect their lives and mental health. Real changes will be put in place to shift practices and culture to ensure consumers' human rights are upheld. This includes efforts to greatly reduce the use of seclusion and restraint, eventually eliminating these practices, and to substantially minimise the use of CTOs.

[25] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) Volume 1, page 619.

Overview

The Victorian Royal Commission's (VRC) findings became the urgent and compelling case for comprehensive reform. These reforms arise from the evidence of an increasing recognition of the 'burden' on consumers of accessing mental health services. Current restrictive practices are the consequential 'service failures' that repeatedly breach consumer's human rights, resulting in the unsatisfactory state of the existing mental health system:

> *'There are missed opportunities to ensure all parts of government and the community are focused on, with not enough focus on promoting good mental health and wellbeing nor preventing mental illness before treatment is needed.*[26]*'*

Radical reform is now being implemented to replace the very costly current *'system driven by crisis'* that has been found to be disengaging and inaccessible:

> *'Limited service availability means...that people do not receive therapeutic support, such as psychological therapies, and wellbeing support, such as assistance connecting with the community, at the time when it would make the most difference.*[27]*'*

As such, the VRC aims for reform will:

> *'Require a collaborative, collective effort and shared responsibility across governments, service providers, community groups, advocates, people with lived experience of mental illness or psychological distress, families, carers and supporters.*[28]*'*

Viewing the present systemic failures that originate from the 19th and 20th century, the VRC made a case for '*comprehensive reform*' away from a reactive system to a proactive system approach, despite recent reviews of the Mental Health Act by the Victorian Auditor-General.[29]

> *''Power imbalances' that disadvantaged and marginalised people living with mental illness or experiencing psychological distress are still apparent. For example, supported decision-making*

[26] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021), Volume 1, page 11.
[27] *Ibid 10.*
[28] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021), Volume 2, page 4
[29] *Royal Commission into Victoria's Mental Health System* (Final Report Summary and Recommendations), page 5

principles and practices, where a person is enabled to make decisions, communicate and have their preferences respected, are not routinely used.'[30]

One powerful witness statement read:

'One glaring flaw is a prevalent lack of respect and recognition of humanity for people with mental illness. Too many are treated as objects rather than human beings, reckless prescribing of medication which is a result of not conducting proper consultation.

The propensity to immediately medicate and not ask questions after unless it was to increase the dosage left me with serious doubts in the nature of mental health care.'[31]

(RCVMHS Final Report, Volume 1, page 395-6)

Fundamental criticisms of the current system have been long known, characterised by the over-medicalisation and clinical paradigm preoccupied by 'illness'. This has resulted in the 'missing middle' of psychosocial servicing for people who are too '*complex'* for primary care but not *'complex'* enough for specialist mental health services. As such, they do not receive adequate treatment and care, if any at all.[32]

The VRC argued the necessity for a *'human rights-compliant approach'* that holds *'a presumption of recovery*', rather than a *'reductionist biomedical model*' which ignores consumers rights and voices:

'Narrow focus of the Mental Health Act on compulsory assessment and treatment means it has little relevance for people who are not subject to, nor at risk of being subject to, compulsory treatment orders'...mental health laws that focus on supporting the needs and preferences of all people would support an equitable and human rights–compliant approach.'[33]

The biomedical model, which prefers the views of mental health practitioners over those of consumers, focuses on 'deficits' that need to be fixed by medication, and is molded around a flawed expectation that the system is responsible for managing short-term risk rather than emphasising recovery. The concept

[30] *Royal Commission into Victoria's Mental Health System* (Final Report Summary and Recommendations, February 2021), page 4.
[31] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021), Volume 1, page 395-6.
[32] *Royal Commission into Victoria's Mental Health System* (Final Report Summary and Recommendations, February 2021), page 9.
[33] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021), Volume 1, page 22.

of ‘personal recovery’ needs to be embedded in every level of our mental health system, supported by Ms Erandathie Jayakody, a witness, who told the Commission that:

> *‘We need a paradigm shift where the law and mental health services are driven on the presumption that people with mental health challenges are capable of managing their own mental health.’*[34]

> *‘Personal recovery means being able to create a meaningful and contributing life, with or without mental health challenges.’* [35]

The reforms are based on the fundamental premise of protecting and respecting consumer’s human rights. Establishing a newly legislated *‘Safer Care - Victoria’* Commission should review and drive change on practices, ensure a transparent and effective system, and develop new ways of providing support.

> *‘In a contemporary mental health and wellbeing system, consumers’ human rights are respected every step of the way. Consumers are supported to make decisions that affect their own lives. Real changes will be put in place to shift practices and cultures, ensuring consumers’ human rights are upheld. This includes efforts to greatly reduce the use of seclusion and restraint, eventually eliminating these practices, and to substantially reduce the use of compulsory treatment so it is only used as a last resort.’*[36]

The VRC recognised that there are opportunities for other system’s responses to be non-punitive or non-coercive to promote recovery, and these exist even in the face of florid distress:

> *‘Crisis should be seen as an opportunity to understand the underlying causes of the person’s distress and connect them with family and community support systems to promote recovery.’*[37]

Restrictive practices are antithetical to ‘recovery’ processes in mental health and wellbeing, and are to be steadily eliminated. Enforceable Community Treatment Orders are kept in reserve as ‘last resort’ but as the system reforms, this too will hopefully become redundant. Whilst it will be a gradual process, the legislative power and efficacy of the Mental Health and Wellbeing entities will be significant in determining that restrictive practices cease.

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[34] *Royal Commission into Victoria’s Mental Health System* (Final Report, February 2021), Volume 1, page 21.
[35] *Royal Commission into Victoria’s Mental Health System* (Final Report Summary and Recommendations, February 2021), page 12.
[36] Ibid 30.
[37] *Royal Commission into Victoria’s Mental Health System* (Final Report, February 2021), Volume 1, page 516.

The criminal justice system 'denies' access to services, and 'poorly' coordinates with the mental health system, failing to offer mental health assistance to those who would most benefit. It also has become the dumping ground for the failures of the mental health system:

> *'People living with mental illness are over-represented in the criminal justice system.... As a result, the justice system, rather than the mental health system, too often becomes the provider of mental health services, or the 'provider of last resort'.'*[38]

Consumers are integral to this reform, engaged in its rebirth and forging new pathways of support, acting as stakeholders at every level. Consumers are already taking new roles: not only as voices to be heard, but in leadership at the table of Safer Care reforms, peer-led agents in newly created support agencies and within a personal self-recovery path that is each individual's right.

[38] *Royal Commission into Victoria's Mental Health System* (Final Report Summary and Recommendations, February 2021), page 16.

Recommendation 53: Strong Oversight of the Quality and Safety of Mental Health and Wellbeing Services

The evidence and findings supporting this recommendation are noted and indexed below.

Transitioning from restrictive interventions or practices to evidence-based and human rights-oriented approaches to recovery requires independent oversight and management. The VRC recognised that it will be challenging to enable the shift systems of care/support, and to transition care reforms safely for others will need to track and guide change, including to hold the providers of the new reforms and to government to account. Thus, new structures and functions of strong oversight are necessary for the provision of accessible information from stakeholders and change-agents of a new system to effectively impact system providers towards reforms being achieved.

This strong oversight capability is the dispatch of a new *Mental Health and Wellbeing Commission*, being detailed, in a unit called the *Safer Care Commission*:

1. Enable the Mental Health and Wellbeing Commission to use its full suite of complaints and oversight functions to monitor, inquire into and report on system-wide quality and safety.
2. Facilitate the Mental Health and Wellbeing Commission to monitor, as matters of priority, the:
    a. Use of seclusion and restraint;
    b. Use of compulsory treatment;
    c. Incidence of gender-based violence in mental health facilities; and
    d. Incidence of suicides in health settings.
3. Enable the Mental Health and Wellbeing Commision to:
    a. Work with the Department of Health and relevant regulators to build a comprehensive understanding of quality and safety issues in mental health and wellbeing services;
    b. Ensure on an ongoing basis that complaint-handling and investigation approaches:
        i. Meet the needs of consumers, families, carers and supporters and
        ii. Support services to resolve concern;
    c. Advise government on issues of concern and areas for improvement; and
    d. Record, report and publish service-level complaints and other relevant data and information.

(RCVMHS Final Report Summary, Volume 5, page 280)

The Final Report by the VRC explicitly claims that upholding the consumer's human rights is its pivotal axis for the urgent reform of our mental health system. To achieve this the VRC called for a new independent and statutory *Mental Health and Wellbeing Commission* that will be established to hold the Victorian Government to account for the mental health system's performance, and enshrined in new legislation. This unit is called the *'Safer Care Commission's*, and its role is to conduct effective leadership, providing strategic targeting and recommendations for governance, monitoring and oversight by the Commission, ensuring system access to digital information about service provision. Beyond the auxiliary role of 'giving voice', consumers/people with lived experience are central to the 'discourse' and the ongoing system redesign. Consumers' representation will be 'foundational' to this unit, and will lead and partner with others in reform efforts to 'transform the system from within'. Provided with the capability to initiate inquiries as well as deal with complaints, the Commission will focus on reducing the use of seclusion/restraint, and compulsory treatment, especially in inpatient settings.

Consumers will have leadership representation within the new Commission, and *'effectively take part in decision making about issues that affect their lives'*:

> *'To elevate mental health and wellbeing as a government priority, system-level governance will be strengthened. A Chief Officer for Mental Health and Wellbeing, whose role will be defined in legislation, will lead the Mental Health and Wellbeing Division in the Department of Health. The leadership of people with lived experience will be foundational to the future system. The new Mental Health and Wellbeing Commission will include Commissioners with lived experience of mental illness or psychological distress and lived experience as a family member or carer. The new Commission will also support people with lived experience of mental illness or psychological distress to fully and effectively take part in decision making about the issues that affect their lives. It will also promote the role, value and inclusion of families, carers and supporters across the mental health and wellbeing system.'*
>
> (RCVMHS Final Report Summary and Recommendations, page 29)

'Designing a new system' requires changes, expands the Commission's interim report, to make 65 recommendations:

> *Turning people away because they 'aren't sick enough' … sends a message that there is a level that needs to be achieved before you're allowed to get better.*

'Good mental health and wellbeing is not just the absence of mental illness; it is the ability to fully and effectively participate in society. This means attention must be paid to a range of factors related to poor mental health—psychological, biological and social—all of which can change over a person's life. Health is not the only priority in promoting good mental health and wellbeing. Other social services, such as housing, education and justice, and the places people live, work and connect, shape people's mental health and wellbeing. Victoria needs to be a place where people look out for one another, build social connections, and treat others with empathy.'

(RCVMHS Final Report Summary and Recommendations, page 3)

It called for a 'new architecture to respond to need', where the future mental health and wellbeing system legislating and funding the new Safer Care Commission. Its role is to ensure people 'fully and effectively take part in decision making about issues that affect their lives'. Furthermore it is driven by the leadership of those with lived experience :

'To elevate mental health and wellbeing as a government priority, system-level governance will be strengthened. A Chief Officer for Mental Health and Wellbeing, whose role will be defined in legislation, will lead the Mental Health and Wellbeing Division in the Department of Health. The leadership of people with lived experience will be foundational to the future system. The new Mental Health and Wellbeing Commission will include Commissioners with lived experience of mental illness or psychological distress and lived experience as a family member or carer. The new Commission will also support people with lived experience of mental illness or psychological distress to fully and effectively take part in decision making about the issues that affect their lives. It will also promote the role, value and inclusion of families, carers and supporters across the mental health and wellbeing system.'

(RCVMHS Final Report Summary and Recommendations, page 29)

In section 3.3 of the final report, on the 'Re-established confidence through prioritisation and collaboration' this newly formed, independent and statutory body will function with:

'Strong foundations create the conditions for the reformed mental health and wellbeing system to be sustained. These relate to effective leadership, governance and oversight, accountability and collaboration across governments and communities, and ensuring that people with lived experience of mental illness or psychological distress are leading and partnering with others in

reform efforts. Ms Mary O'Hagan MNZM, former New Zealand Mental Health Commissioner and current Manager of Mental Wellbeing at Te Hiringa Hauora, New Zealand, gave evidence in a personal capacity and emphasised:

> *'The reforms we need are not about 'giving greater voice' to people with lived experience. Rather, we need to transform the system from within, so that those voices are central to the discourses and are deeply heard*.'

A new independent and statutory Mental Health and Wellbeing Commission will be established to hold the Victorian Government to account for the performance of the mental health and wellbeing system and the implementation of the Commission's recommendations. The new Commission will be able to initiate its own inquiries into matters that support its objectives. As part of efforts to strengthen oversight, the new Commission will also take on responsibility for responding to complaints.'

(RCVMHS Final Report Summary and Recommendations, page 29)

'*Safer Care Commission - Victoria* - as a legislated reform body, and from within consumers co-create to *'eventually eliminating'* seclusion, restraint & CTO's. Directed through the leadership of people with lived experience, in its design and decision-making, and quality and safety reviews, the implementation of legislatively binding oversight functions of a new 'Safer Care Commission' is specifically aimed to reduce the use of seclusion, restraint and compulsory treatment:

> *Safer Care Victoria to support a new approach to improving quality and safety that embeds contemporary and multidisciplinary approaches in services. The unit will focus on reducing the use of seclusion, restraint and compulsory treatment and on tackling the unacceptable rate of gender-based violence, particularly in inpatient settings.*
>
> *The Commission's reimagined mental health and wellbeing system will be enshrined in legislation—a new Mental Health and Wellbeing Act. The new Act will reflect the vision for the future system and will promote good mental health and wellbeing.'*

(RCVMHS Final Report Summary and Recommendations, pages 33-34)

With a consumer-rights orientation at its core, the aim is to eliminate seclusion and restraint, and 'substantially reduce' to only use 'compulsory treatment' as a 'last resort':

'In a contemporary mental health and wellbeing system, consumers' human rights are respected every step of the way. Consumers are supported to make decisions that affect their own lives. Real changes will be put in place to shift practices and cultures, ensuring consumers' human rights are upheld. This includes efforts to greatly reduce the use of seclusion and restraint, eventually eliminating these practices, and to substantially reduce the use of compulsory treatment so it is only used as a last resort.'

(RCVMHS Final Report Summary and Recommendations, pages 34)

This strong oversight capability is the dispatch of a new 'Mental Health and Wellbeing Commission', being detailed, in a unit called the *Safer Care Commission*. The creation of the *Mental Health and Wellbeing Commision* will be legislated with the capacity to use its full suite of complaints and oversight functions to monitor, inquire into and report on system-wide quality and safety.

This new architecture enables the *Mental Health and Wellbeing Commission* to monitor, as '*matters of priority'*, the staging of a gradual reduction and eventual elimination of restrictive practices of seclusion and restraint and compulsory treatment (RCVMHS Final Report Summary and Recommendations, page 90). This includes the development of measuring not only at the individual level, but also at the level of population outcomes, to make way for new ways of funding and commissioning across the system. At every level, the system is to be '*oriented to and valued based on individual outcomes which measure consumers/individual's experiences in the short to long term'*, including the development of consumer-reported outcomes measures (RCVMHS Final Report, Volume 1, page 111).

The new architecture of reforms will require both a new mental health Act, and funding - Victoria says it is underway to achieve both. The Commission's 'reimagined' mental health and wellbeing system will be enshrined in legislation - a new *Mental Health and Wellbeing Act*:

'The new Act will reflect the vision for the future system and will promote good mental health and wellbeing:

A key part of improving people's experiences and outcomes is ensuring that the quality and safety of mental health and wellbeing services are of the highest standard. A Mental Health Improvement Unit will be established within Safer Care Victoria to support a new approach to improving quality and safety that embeds contemporary and multidisciplinary approaches in services. The unit will focus on reducing the use of seclusion, restraint and compulsory treatment and on tackling the unacceptable rate of gender-based violence, particularly in inpatient settings.

Services will be commissioned in new ways to respond to the diverse preferences and expectations of people living with mental illness or psychological distress, families, carers and supporters. Investment in mental health and wellbeing will be made a priority through the implementation of the levy recommended in the interim report. There will also be substantial changes to the way services are planned, funded and monitored, ensuring that providers meet people's expectations and that services are achieving the outcomes that are most important to consumers, families, carers and supporters.'

(RCVMHS Final Report Summary and Recommendations, page 29)

Working closely with the new Commission, a new '*Mental Health Implementation Office'* will be established as an office in relation to the *'Victorian 'Department of Health and Human Services'*, and investment in mental health and wellbeing will be made a priority through the implementation of a new levy/tax to fund the new system and structures, such as *'Safer Care-Victoria'* and any new ways of support that evolve from its functions (The Royal Commission Interim Report Summary 2019, page 23).

A Staged Approach, & It Comes Out Of NSW

VRC calls for new oversight structure to be responsible in progressively staged, phasing out of seclusion and restraint, with the introduction of the setting and meeting annual targets to reduce the use and duration of compulsory treatment on a year-by-year basis, and to eventually stop complete seclusion and restraint. The Royal Commission Report in Volume 4, Chapter 31, addressed restrictive practices in detail and the priority of reducing Seclusion and Restraint, and also the use of psychotropic drugs. It concurred with the United Nations that all these restrictive practices are to be eliminated, on the basis of consumer rights; that all restrictive practices were deemed '*service failures'* that are *'incompatible with recovery'* approaches; and that they resulted in the '*damaging impact of retriggering or conflating their use with past abusive relationship trauma'*, and its conflating or had '*adverse impact on the nurturing therapeutic relationships'.*

The setting of annual targets will provide a staged approach to reduce restrictive practices.

Successful implementation of new regional governance structures will require new capabilities and skills to be acquired. This will take time and dedication, and forming new relationships and trust:

'All Together, a report developed by the Sydney Policy Lab from the University of Sydney, said the first principle of commissioning human services in New South Wales should be putting relationships first, stating that the core challenge 'is changing from transaction governance and models of operating to ones that are relational.'

In a contribution to a recent review of the Australian public service, Janine O'Flynn and Gary Sturgess similarly described that commissioning public services needs to emphasise community participation:

> *Commissioning should be anchored to community needs and aspirations, not decisions made by government for communities, and may well be a catalyst for more local solutions rather than central decisions; partnership rather than paternalism.*

Continuous communication and developing trust are identified as conditions of collective success:

> *Developing trust among nonprofits, corporations, and government agencies is a monumental challenge. Participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts. They need time to see that their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.*

A staged approach to implementing the functions of the new Regional Boards will allow for trusting partnerships to be developed between the department, these new entities and service providers, as well as their respective communities (refer to Figure 5.13). This includes relationships with public health services and public hospitals, which will continue to be accountable for delivering health services.'

(RCVMHS Final Report, Volume 1, page 271)

System Access To Digital information

Digital information technology will enable system access, requiring service providers to provide a minimum digital functionality - to advance reforms in navigating the continuity of care and its navigation of 'contemporary and adaptable services':

'The future system will be enabled through digital technology. To improve system access, continuity of care and navigation, service providers will be required to provide minimum digital functionality, and they will be helped to achieve this. A new approach to information management will be established in partnership with consumers, to help collect, use and share information across the system effectively, safely and efficiently.

The system will continue to evolve and respond to the expectations of people living with mental illness or psychological distress, families, carers and supporters. Innovation in treatment, care and support will be promoted through a dedicated mental health and wellbeing innovation fund, and services will be helped to implement and test new approaches. There will be a strong focus on translational research (testing and applying new treatments and models of care in service delivery environments) that is led and co-produced with people with lived experience of mental illness or psychological distress. Evaluation will be widespread, and providers of all new mental health and wellbeing programs will need to agree to evaluation as part of funding arrangements.'

(RCVMHS Final Report Summary and Recommendations, page 34)

Recommendation 54: Towards the Elimination of Seclusion and Restraint

The evidence and findings supporting this recommendation are noted and indexed below.

The Royal Commission recommends that the Victorian Government:

- Act immediately to reduce the use of seclusion and restraint in mental health and wellbeing service delivery, with the aim to eliminate these practices within 10 years.
- Regulate the use of chemical restraint through legislative provisions in the new Mental Health and Wellbeing Act (refer to recommendation 42(2)(e)).
- Ensure the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)) develops and leads a strategy to reduce the use of seclusion and restraint.
- Enable the *Mental Health Improvement Unit* within *Safer Care Victoria* (refer to recommendation 52(1)) to co-design with mental health and wellbeing services, and people with lived experience a range of programs and supports aligned with the strategy that focus on working with each mental health and wellbeing service to:
    - Investigate local data and practices in order to identify priority areas for change.
    - Making workforce training available for services.
    - Continuing to support services to embed *Safewards* (RCVMHS Final Report Summary and Recommendations, page 91).

The Commission's recommendations regarding reducing the use of restrictive interventions or practices[39] were detailed in Chapter 31: Reducing seclusion and restraint (RCVMHS Final Report, Volume 4).

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[39] Definitions of Seclusion and Restraint:
Definitions relating to restrictive interventions such as seclusion and restraint have been included as they are terms used in the legislation. The terms are also used in clinical and custodial practice, thus it is important to understand the context in which they are used.
The definition of 'Seclusion and restraint':

> *The Mental Health Act 2014 (Vic) currently defines two forms of 'restrictive interventions':*
>
> *• Bodily restraint is a form of physical or mechanical restraint that prevents a person having free movement of their arms or limbs but does not include the use of furniture (including beds with cot sides and chairs with tables tted on their arms) that restricts the person's ability to get off the furniture.*
>
> *• Seclusion is the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.*
>
> *Under the Act, seclusion and restraint can only be used in designated mental health services.*
> *The Act also prescribes that restrictive interventions (including seclusion and restraint) may only be used after 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.*
>
> *Restrictive interventions can also be called 'restrictive practices'.*
>
> (RCVMHS Final Report, Volume 1, page 672)

These restrictive interventions were defined, and noted in *Box 31.1: Defining seclusion and restraint*

> *The Mental Health Act 2014 (Vic) currently defines two forms of 'restrictive interventions':*

Restrictive practices[40] are deemed by the Commission to be 'service failures' and these comprise of: 'Compulsory Treatment'[41] (including the use of psychotropic medications), Seclusion and Restraint. It summarised the root objection to restrictive practices as:

> *'The Commission highlighted the profound, dehumanising and often long-term negative effects that seclusion and restraint can have. Consumers described their experiences as 'triggering', 'Disempowering', 'traumatising' and 'controlled'. Rates of both seclusion and physical restraint in public acute clinical mental health services in Victoria are worse than the national average, despite efforts to reduce their use. Individuals and organisations have called for the elimination of restrictive practices in the Victorian mental health system.'*
>
> (RCVMHS Final Report, Volume 4, page 298)

The Commission reported on its *'service failures'* in using restrictive interventions/practices*:*

> *'The use of seclusion and restraint restricts a person's freedom of movement and may constitute cruel, inhuman or degrading treatment under international human rights law. The United Nations Committee on the Rights of Persons with Disabilities has expressed concerns about the use of seclusion, physical restraint and psychotropic medications (antidepressants and other medications that affect people's emotions and behaviours) in Australia and urged the elimination of restrictive practices in all settings.*

> *• Bodily restraint is defined as a form of physical or mechanical restraint that prevents a person having free movement of their arms or limbs but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.*
> *• Seclusion is defined as the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.*
> *Under the Act, seclusion and restraint can only be used in designated mental health services.*
> *The Act also prescribes that restrictive interventions (including seclusion and restraint) may only be used after 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.*
> *Restrictive interventions can also be referred to as 'restrictive practices'. The term 'restrictive practices' is used in this chapter and throughout the report when necessary to reflect the use of the term in source data or evidence.*
>
> (RCVMHS Final Report, Volume 4, page 298)

[40] 'Restrictive Interventions' can be the use of Seclusion and/or Restraint:
May include 'bodily restraint', which is defined as a form of physical or mechanical restraint that prevents a person from having free movement of their limbs (excluding the use of furniture), or 'seclusion', which is the sole confinement of a person to a room or any other enclosed space from where the person is not free to leave (RCVMHS Final Report, Volume 1, page 671)

[41] Compulsory Treatment, or 'involuntary treatment' was defined as:
The treatment of a person for mental illness subject to an order under the Mental Health Act 2014 (Vic), the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) or the Sentencing Act 1991 (Vic). This can include the administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. Compulsory treatment is sometimes referred to as 'involuntary treatment'. (Final Report, Volume 1 P658)

There is widespread commitment to reducing and, where possible, eliminating the use of restrictive practices within Victorian mental health and wellbeing services. In submissions to the Commission, many organisations called for eliminating or prohibiting seclusion and restraint in mental health services. Across the system, there have been—and continue to be—significant efforts to minimise and, where possible, eliminate use.

In recent years the use of seclusion and restraint has often been described as a service failure. As the Mental Health Legal Centre stated:

Restraint and seclusion no longer have a place in mental health care and their continued use highlights a mental health system operating in a bygone era. The experience of our clients demonstrates that much more needs to be done to change the culture within services and to ensure that the safeguards we have are adequate and actually followed by those on the front line.'

(RCVMHS Final Report, Volume 4, page 299)

The final report found the current system was *'overwhelmed', 'crisis-driven'*, and with an '*over-reliance'* on medication. This was compounded by evidence taken that revealed that many had concerns about medication use; that the perspectives of people with mental illness were largely overlooked, and families and carers were left out; that stigma and discrimination were ever present; and services were difficult for many people to afford.

Restrictive interventions or practices referred to by VRC included both physical and chemical forms of restraint, however there was only some mention about *'chemical restraint'* as a form of 'restraint'. *'Chemical restraint*' refers to using medication to control behaviour. There has been continuing debate about the use of chemical restraint in mental health treatment, care and support. Research indicates that, despite interest in understanding the use of chemical restraint, there is still limited agreement on if and how chemical restraint should be used in the context of mental health treatment, care and support. There is mention in the Commission including concerns about psychotropic medication in relation to restrictive interventions. However, overmedication or medication with major sedatives was given insufficient focus by the Commission, and respond to people's concerns about medication and its overuse/over-reliance and side effects to poor communication and education methods rather than critique of their sedating effects on languishing lives, their severe short and long term side-effect risks, and especially in regards to other long term health consequences:

'Most medical treatments used in mental health services are 'psychotropic' medications to ease the symptoms of mental illness or psychological distress (for example, antipsychotic medication and anti-anxiolytics to help people experiencing high levels of anxiety)...

Despite frequent misgivings about medication side effects, some consumers emphasised that they need medication to cope with the symptoms of their mental illness or psychological distress. The following quotes provide two examples of this feedback:

> *I know I need it, but I hate it so much ... I hate the drooling and the weight gain ... [but I need it because] it's been the best for my psychosis ... It has kept me out of hospital.*
>
> *I have had several psychologists and other health professionals tell me to reduce my medication. I've tried it–it doesn't go well.*

However, considerable evidence before the Commission indicates a need for better prescribing and medication management and monitoring practices in Victoria's mental health and wellbeing system. This is consistent with the high number of complaints about medication prescribing—in 2017–18, complaints about medication constituted 19 per cent of new submissions to the Mental Health Complaints Commissioner.

...According to the Mental Health Complaints Commissioner, a common concern is that mental health services do not adequately consider or respond to consumers' concerns about medication side effects. This was also a strong theme in evidence received by the Commission. The following quote is illustrative:

> *There needs to be more [doctor] awareness of bad side effects and the [doctors] need to listen if a person has a complaint about the medication, rather than the [doctors] making out as though the 'bad side effects' are part of the person's mental condition. There needs to be more awareness of the rights of people. More advertising on wards regarding how someone has rights and how to get support and [a] second opinion if desired.'*

(RCVMHS Final Report, Volume 1, page 395)

'Also, Many consumers spoke to the Commission about these 'bad side effects.' For example, witness Mr Dave Peters said:

> *[The] physical health of people with mental illness can be affected by the medications they take for their mental illness. In addition to the significant impacts on physical health and life expectancy ... certain medications can have a terrible impact on oral health. In addition,*

the sedation effects of some medications can cause the people taking them to suffer from apathy and disengagement from life. That is something that I still struggle with.

Apart from the medication side effects noted by Mr Peters, many psychotropic medications are known to dramatically increase appetite. This can result in physical health challenges such as excessive weight gain and related health problems.

Given the potentially serious nature of these side effects, the Commission is concerned by evidence of poor prescribing practices, including a lack information about the medications given by clinicians administering the products

… The need for expert pharmacological management and support for consumers, families, carers and supporters, to participate in decision-making around medications, is heightened by the fact that many consumers are on several different medications. As shown in Figure 7.4, consumers of public specialist mental health services were much more likely to be dispensed six or more scripts than other Victorians who were dispensed mental health-related scripts under the Pharmaceutical Benefits Scheme in 2017–18.155 High levels of medication, and the use of multiple medications, increases the chance of medication errors and adverse reactions.'

(RCVMHS Final Report , Volume 1, page 396)

The Commission stated that the Victorian Government should introduce similar requirements into the new *Mental Health and Wellbeing Act*, where *'chemical restraint is only permitted when all reasonable and less restrictive options have been tried, or when they have been considered and are thought to be unsuitable'* (RCVMHS Final Report, Volume 4, page 344). It added that *'in the absence of a definition in legislation or policy, some service providers have taken action to reduce over-sedation and other undesirable side effects'* (RCVMHS Final Report, Volume 4, page 332-335).

Furthermore, the Commission urged that '*recovery orientated services delivered are of a high-quality and safe treatment, care and support, without the need for seclusion, restraint and other coercive practices. The leadership and involvement of consumers in the process is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'* (RCVMHS Final Report, Volume 4, page 332-335).

Emphasising that a 'patient-centred approach' will improve matters as non restrictive alternatives to seclusion and restraint are adopted, and this is beneficial not only for patients but for staff:

'*The Commission is concerned that the safety and wellbeing of staff is being compromised in a system that is under pressure and under-resourced, which will act as a barrier to achieving high standards of professional practice, treatment and care. As Professor Newton advised:*

'Having safety as a central tenet for all staff and consumers is an important component of culture. If services take a patient-centred approach informed by human rights they will be able to positively influence the use of restrictive practices.'

Mental health services are unlikely to eliminate the use of seclusion and restraint unless staff feel safe at work.160 This will require alternatives—such as early intervention or de-escalation techniques—that allow staff to respond to consumers without restrictive practices. These alternatives have been used to good effect elsewhere (refer to Box 31.5).

Professor Newton noted:

'If staff react to aggressive behaviour by attempting to restrain a consumer, it may only worsen the consumer's behaviour and increase the risk of harm to the staff member. Where staff use alternative techniques, including de-escalation, the clinically observable result is that patient behaviour improves, making a safer environment for both patients and staff.'

Mental health services need alternatives to restrictive interventions to improve the safety of consumers and staff and to reduce the use of seclusion and restraint. International studies have identified ways to prevent conflict, support earlier intervention in situations that lead to seclusion and restraint, and enable staff to use de-escalation techniques.'

(RCVMHS Final Report, Volume 4, page 326)

Shared Care Approach

The Commission restructure emphasised the system of reforms reorient away from a 'clinical paradigm' that has an illness focus to that of mental health and well-being and to ensure 'real person-centred recovery':

'Concerns have been expressed that the current service offering is overly focused on prescribing medication and that it fails to respond to a person's preferences or their broader needs. People have said there is a lack of effective wellbeing supports or approaches that respond to experiences of trauma or recovery-based responses. Ms Julie Dempsey, a witness before the Commission, explained:

> *Current psychiatric units were set up as attachments to mainstream hospitals as a **move to integrate back into wider society, away from the isolation of the old asylums. However, what this has achieved is an intensification of the medical model at the cost of real person-centred recovery**.*

*The **dominance of a clinical paradigm** in the current service offering is also considered at odds with Aboriginal cultural understandings of mental health, which are based on beliefs about the inextricable connections between a person's physical, emotional, spiritual well being, their community and the environment. As highlighted in the Ways Forward report, for Aboriginal people 'health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community.'*

Structural problems, such as major supply problems and a crisis-driven approach, have adversely affected the workforce's ability to work effectively and deliver the types of services people seek.'

(RCVMHS Final Report, Volume 1, page 194)

'Focus is on 'personal recovery' not 'clinical recovery'.'

(RCVMHS Full Report, Volume 4, page 25)

'As well as wanting to offer more non-medication clinical therapies, leaders from mental health services and non-government organisations told the Commission that it is time to end the divisions and binary ways of thinking that separate 'clinical' treatment, care and support from 'psychosocial' approaches, and to stop thinking of the organisations delivering them as having essentially different roles. For example, as Dr Shaymaa Elkadi, Executive Director of Strategy, Planning and Performance at Forensicare, summarised:

> *'[t]here is a need for continuity of care and a shared care approach between clinical care and psychosocial support. The two areas currently operate in silos.'*

(RCVMHS Final Report Volume 1, page 382)

System Problems That May Increase Restrictive Practices And Perpetuate Behaviours Of Concern And/Or Add To Trauma

'A failing system can itself cause trauma, and 'trauma is unseen', with a need for trauma-informed mental health treatment, care and support.'

(RCVMHS Final Report Summary Plain Languages Version, page 13)

The serious emotional and relational system fallout was underscored in several statements by witnesses. Elizabeth spoke of her own traumatic experiences, following being hospitalised three times against her will and restrained on all admissions, of which twice she was put into seclusion :

'Being restrained reminded me of being raped.

I think seclusion has no therapeutic value—it's done for the convenience of the institution. I feel that I've recovered from my mental health conditions in spite of, not because of the mental health system.'

(RCVMHS Final Report, Volume 4, page 248)

Ms Lucy Barker, said of her own experience:

'being part of the mental health system is kind of like being in an abusive relationship. You're being told that they care about you and they can help you and that they're there for you, but then they hurt you so much with restraints, seclusion, medications and talk about you in horrific ways. There's nowhere else for you to turn to ... I'm stuck in that relationship with the system.'

(RCVMHS Final Report, Volume 4, page 27)

Ms Anna Wilson speaking about her son being often locked up:

'I have often not been treated with dignity or respect. I have been pushed aside because staff are busy. Mental health workers have said to me 'I can't talk to you' or 'I'll let you go'.

I have also not been believed. Usually, Harold will not open the door because he is afraid of being locked up and placed under a Treatment Order made under the Mental Health Act, which has happened many times.

I have felt so disempowered and exhausted from constantly battling to get my son the support and care he needs. I believe strongly that we have to improve the mental health system. It is shocking what consumers and their carers are going through.'

(RCVMHS Final Report, Volume 4, page 27)

'We need approaches in which we deliberately and proactively try to understand issues around power.'

(RCVMHS Final Report, Volume 3, page 19)

In the Final report volume 1, 10.2.1 'A system under pressure' recognised some of the problems created in the hospital setting is that it contributed to more volatile inpatient environments that increased restrictive practices and compulsory treatment:

'High occupancy rates of consumers with highly acute mental health presentations, contributing to more volatile inpatient environments and increased rates of interpersonal violence, restrictive practices, compulsory treatment and staff turnover.'

(RCVMHS Final Report, Volume 1, page 590)

Inadequate care responses can be traumatic for the consumer and for others. While the majority of consumers in acute inpatient settings are not violent or aggressive, Staff need to respond to the needs of each consumer and to keep staff safe, when these behaviours do occur:

'This includes the need for staff to have the skills to respond to these behaviours in the least restrictive and most therapeutic way possible.

Inadequate care responses can be traumatic for the consumer and for others in the ward. Rather than receiving highly specialised therapeutic support, consumers in the current system who demonstrate violent or threatening behaviours are often subject to compulsory or restrictive practices. As noted by Professor Newton:

> *If consumers and carers are able to easily access adequate mental health services and receive effective treatment, then they are less likely to be distressed and to manifest that distress through aggression. The currently impoverished service system sets up many consumers and carers to feel more distressed as they try and obtain the right treatment or care.*

Evidence suggests that being subject to compulsory or restrictive practices can simply perpetuate the behaviours of concern, as well as trauma associated with the event. For others in the ward, witnessing such practices can be traumatising and undermine the therapeutic nature of what should be an environment for healing and recovery. The Commission also heard that mental health and wellbeing staff can find it challenging to work in cultures that sanction restrictive practices.'

Dr Coventry summarised the impacts of these incidents:

'Aggression on inpatient units poses multiple hazards. For those inpatients who behave aggressively, the consequences may include physical restraint, injected medications and seclusion, sometimes for lengthy periods. The consumer and staff members involved in the incident may be injured and the other consumers who witness it are likely to experience great anxiety. Repeated episodes of aggression are likely to result in feelings of mistrust and resentment by consumers toward staff and, for staff members, high levels of absenteeism and burnout. These sequelae make it difficult to provide a hope-filled, therapeutic environment for those admitted to the unit and a congenial, rewarding workplace for clinicians.'

The commission followed this with:

'While a recent study indicates there is 'limited evidence that mental health problems are independent predictors of violence when accounting for other factors, such as substance use or previous violence', several submissions raised concerns about increasing rates of violence within acute mental health facilities.'

(RCVMHS Final Report, Volume 1, Page 626-627)

Lifting General Wellbeing, Not Coercion - Reducing Seclusion & Restraint

Seeking a new service system based on non-coercive approaches, the Commission said:

'In addition, reducing the need for consumers to visit emergency departments or be admitted to inpatient units to access treatment, care and support is consistent with a human-rights based approach to non-coercive options provided through community-based service offerings. Treatment, care and support provided to people earlier, and in the community, may reduce the likelihood of a person experiencing compulsory treatment, seclusion and restraint. This

responds to broader concerns that consumers have about human rights issues in clinical mental health environments, leading many to suggest community-based care as a less restrictive option.'

(RCVMHS Final Report, Volume 1, Page 315)

Calling for all restrictive practices to cease, the Royal Commission Report in Volume 4, Chapter 31, addressed reducing Seclusion and Restraint, and also the use of psychotropic drugs. It concurred with the United Nations that all these restrictive practices are to be eliminated, on the basis of consumer rights, service failures, its incompatibility with recovery approaches, the damaging impact of retriggering or conflating their use with past abusive relationship trauma, and its conflating/adverse impact on the nurturing therapeutic relationships:

'The United Nations Committee on the Rights of Persons with Disabilities has expressed concerns about the use of seclusion, physical restraint and psychotropic medications (antidepressants and other medications that affect people's emotions and behaviours) in Australia and urged the elimination of restrictive practices in all settings

[The] *Commission considers that working towards eliminating seclusion and restraint—within the context of a redesigned system—is necessary to uphold the rights of consumers and to respond to service failure. Over time, early intervention, less compulsory treatment, well-designed facilities, increased staffing levels and better training and support will remove the need for practices of 'last resort' and establish alternative approaches as routine practice. Any lesser aspiration will impair the efforts to achieve a system that is safe for both consumers and staff, and that provides the highest standard of treatment, care and support for people experiencing severe distress or who are in crisis*

the use of seclusion and restraint conflicts with recovery-oriented and trauma-informed practice. Ms Cath Roper, Consumer Academic in the Centre for Psychiatric Nursing at the University of Melbourne, told the Commission, 'you cannot use recovery principles to seclude someone. Seclusion and recovery-oriented principles do not go together.''

(RCVMHS Final Report, Volume 4, page 299-301)

'The experience of seclusion and restraint can also be retraumatising; that is, it can cause people to 'relive' earlier trauma. Many consumers of mental health inpatient services report a history of trauma, neglect and physical or sexual abuse. Many have also experienced institutionalised care or time in custody, with systems that can feel controlling rather than therapeutic, leaving the

person carrying trauma from their time in these services. Experiences of seclusion and restraint can 'reawaken' trauma by 'creating a similar power dynamic to past relationships of abuse.''

(RCVMHS Final Report, Volume 4, page 304)

The Final Report, Volume 1, 3.2.1 'Mental health outcomes approaches have been narrowly applied' recognised how a narrow focus may result in increasing restrictive practices. The Commission discussed how using narrowly focused mental health outcomes measures also risks 'skewing' the attention within both services and the system more broadly. James Mansell, an independent consultant working on state sector reforms in New Zealand, advised that a broad range of indicators are needed for a 'balanced system' in practice:

'Indicators overly focused on ... high-risk adverse events tend to skew the system towards being too coercive and too focused on tertiary responses and risk management, rather than on lifting general well-being.

Adopting a narrow range of outcomes measures can have unintended consequences. For example, if services adopt a narrow focus to manage occupational safety, they may become over-reliant on risk management and assessment, which in turn may lead to increased use of restrictive practices (further discussed in Chapter 31: Reducing seclusion and restraint). Mental health services need other options to improve the safety of consumers and staff, and to reduce the use of seclusion and restraint. This includes alternatives that respond to increasing distress or agitation, help prevent conflict and enable earlier interventions (de-escalation). Adopting a comprehensive outcomes framework can support this by broadening the approach of service delivery beyond the sole focus of managing risk, to instead simultaneously provide safe environments for consumers and staff and promote delivery of recovery-oriented treatment, care and support, and uphold the rights of consumers.

Finally, it is important that outcomes measures, once properly and comprehensively established, are applied across multiple settings and cohorts. As the Victorian Auditor-General acknowledged in a 2019 review of Victoria's mental health system, indicators of the outcomes within Victoria's 10-Year Mental Health Plan are currently only collected for people living with mental illness or psychological distress who are already in contact with the mental health system:

There are few measures in the outcomes framework for the 10-year plan that directly capture performance against providing access to services or increasing service reach—this is despite the acknowledged performance problems in this area—which shows a lack of focus on the most pressing issue the system faces.'

(RCVMHS Final Report, Volume 1, page 100)

Specialists And The Need For 'Alternate' Humane Responses Or A Non-Coercive Approach, Like De-escalation And Anticipating Potential Traumatic Triggers

It then commented on concerns of increased rates of seclusion. Approaches to reduce the use of seclusion seemed obvious. An example was the response by Alfred Health, that was detailed in Box 10.4. Taking a 'non-coercive approach' it referred to strategies like: verbally de-esculating using sensory modulation, and to 'work directly with the consumer to de-escalate the situation', and staff being 'informed by an understanding of triggers' for the client, and changing operational procedures for intake/transer where mechanical restraint or seclusion are indicated; staff anticipating bad news being delivered to avoid consumers from absconding':

'When called to a unit, they discuss the current situation, consider what strategies have been tried already and evaluate what resources are required. They can also, in consultation with the treating team, work directly with the consumer to de-escalate the situation.
The approach is informed by an understanding of triggers that can cause an escalation of distress or agitation, or operational scenarios where the risk of needing to use seclusion or restraint are high. For example, Alfred Health requires inpatient-unit staff to make a mandatory call to the Psy-BOC team when a consumer is arriving under transfer where mechanical restraint or seclusion are indicated, or where there is disinhibited behaviour. Staff are also encouraged to make calls in advance of bad news being delivered or when a consumer returns from absconding.'

(RCVMHS Final Report, Volume 1, page 628)

Eliminating Seclusion And Restraint Progressively, Via Annual Targets To Reduce The Use/Duration Of Compulsory Treatment

VRC calls for the introduction of targets to reduce the use and duration of compulsory treatment on a year-by-year basis, and to eventually completely stop seclusion and restraint.

The final report found the system was overwhelmed and could not keep up with the number of people who sought treatment. There was an over-reliance on medication, the perspectives of people with mental illness were overlooked, families and carers were left out, stigma and discrimination were ever present and services were difficult for many people to afford (RCVMHS Final Report Summary and Recommendations, page 23).

There is a commitment made to consumers that goes beyond the acute response, where a newly appointed *Mental Health and Wellbeing Commission* will have powers to seek data and information, to report publicly, and to highlight change:

> *'The Victorian Government will be accountable for the quality and safety of services provided across the state, and services will be required to continuously improve service delivery. They will also need to greatly reduce the use of compulsory treatment so it is only used as a last resort; and work towards eliminating the use of seclusion and restraint in the mental health and wellbeing system, including emergency departments ... The Mental Health and Wellbeing Commission will have powers to seek data and information, to report publicly, and to highlight changes to protect the safety and rights of consumers.'*
>
> (RCVMHS Final Report, Volume 1, page 5)

The Commission directed the establishment of new bodies and roles, including the Mental Health and Wellbeing Commission (recommendation 44), the Chief Officer for Mental Health and Wellbeing (recommendation 45(1)) and Regional Mental Health and Wellbeing Boards (recommendation 4(2)). Their roles include: strengthen 'accountability mechanisms and monitoring arrangements for service delivery'; and 'specific measures to reduce rates and negative impacts of compulsory assessment and treatment, seclusion and restraint'...

(RCVMHS Final Report, Volume 1, page 11)

Recommendation 55: Ensuring Compulsory Treatment is Only Used as a 'Last Resort'

The evidence and findings supporting this recommendation are noted and indexed below.

An aspect of 'restrictive' interventions or practice is 'Compulsory Treatment', or 'involuntary treatment'. This is a focus of reforms that are to be controlled by new legislated bodies, such as the Commission and Safer Care Victoria, to control the staged phase out and eventual elimination of such practices. 'Compulsory treatment' is incongruous with contemporary mental health practices based on a 'recovery' and 'person-centred' orientation. While the VRC recommended that consumer leadership and participation in reform building will reduce the use and duration of use of this coercive practice in favour of 'non-coercive options', it retained this option as a practice of 'last resort', which is to be reduced in its use. 'Compulsory Treatment' is defined as:

> *'The treatment of a person for mental illness subject to an order under the Mental Health Act 2014 (Vic), the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) or the Sentencing Act 1991 (Vic). This can include the administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. Compulsory treatment is sometimes referred to as 'involuntary treatment'.*

(Final Report, Volume 1, page 658)

The Royal Commission recommends that the Victorian Government:

1. act immediately to ensure that the use of compulsory treatment is **only used as a last resort.**
2. set targets to **reduce the use and duration of compulsory treatment** on a year-by-year basis and gather and publish **service-level and system-wide data** in this regard.
3. when commissioning mental health and wellbeing services, set expectations that they will provide **non-coercive options** for people living with mental illness or psychological distress, including those at risk of compulsory treatment, in both Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.
4. ensure the Mental Health Improvement Unit within Safer Care Victoria (refer to recommendation 52(1)) works with mental health and wellbeing services to:
    a. **increase consumer leadership and participation** in all activities to reduce compulsory treatment;
    b. support the design and implementation of **local programs,** informed by data, to reduce compulsory treatment; and
    c. make available **workforce training on non-coercive options** for treatment that is underpinned by **human rights** and supported decision-making principles.
    d. provides care and support to people earlier to prevent consumers from being subject to compulsory treatment.

(RCVMHS Final Report, Volume 1, page 91)

‘Distress’, ‘Harmful’ Consequences And Poor Evidence Basis Of Using Compulsory Treatment - ‘Unintended’ Consequences Of ‘Default’ Practice

The VRC Final Report Volume 1 outlines compulsory treatment orders, ‘contribute to unintended consequences including the default use of compulsory treatment’ (RCVMHS Final Report, Volume 1, page 198). The Commission highlighted that: *‘*Treatment, care and support provided to people earlier, and in the community, may reduce the likelihood of a person experiencing compulsory treatment, seclusion and restraint*’,* (RCVMHS Final Report, Volume 1, page 315) and should be the preferred treatment, compulsory treatment orders only being used as a last resort.

Consumers described the serious and harmful consequences of being subject to compulsory treatment. This included distress and disempowerment—including deep fears for their safety and experiences of significant trauma as a result of being subject to treatment against their will. This is particularly concerning for people from Aboriginal backgrounds who are over-represented on compulsory assessment and treatment orders, and especially in the context of the dispossession and intergenerational trauma already wrought by colonisation and post-invasion government activity. Severe, long lasting and traumatic experiences can also be imposed due to the adverse effects of compulsory electroconvulsive treatment. Some of these personal accounts included:

> *When you’re a compulsory patient, you’re staring at the walls. There’s nothing to do—no therapy, no programs. There was a broken piano and a few broken crayons. Everyone’s contained in one small space.*
>
> *The compulsory treatment order made it hard for me to experience good mental health. I felt as if my basic human rights were taken away from me.*
>
> *My three compulsory admissions for psychotic episodes were actively harmful, caused intense suicidal ideation related to being assaulted by male patients during the admissions, and in significant ways, were more challenging to recover from than my mental health conditions.*
>
> (RCVMHS Final Report, Volume 4, page 370)

For distressed people who call Emergency 000 to *‘just to get services to arrive*’, or who experience police involvement, ‘*Police arrive, and then often you’re treated worse than perpetrators in the justice system*’, and for families, it can also be *‘traumatic’*.

(RCVMHS Final Report, Volume 4, page 371)

Representations made to the commission for the immediate cessation of compulsory treatment via the use of non-coercive approaches that engage supported decision-making called for:

> *I will continue to advocate for the abolition of compulsory treatment. In the meantime, we should reduce the rate at which compulsory treatment is used by enacting a framework for supported decision-making.*
>
> *I would be delighted to see an immediate end to compulsory treatment, however I recognise this is highly unlikely to occur in the immediate future. So instead, I suggest a gradual reduction in compulsory detention and treatment could be supported …*
>
> *I would very strongly support the abolition of involuntary treatments to be done in the context ... of providing all those other necessary supports ...*
>
> (RCVMHS Final Report, Volume 4, page 371)

Legal experts and human rights advocates have called for the radical reduction, or abolition, of compulsory treatment. Tina Minkowitz, a human rights lawyer, founder of the Center for the Human Rights of Users and Survivors of Psychiatry and who has helped draft the Convention on the Rights of Persons with Disabilities, stated:

> *Any legal provisions that make exceptions to free and informed consent for any persons with disabilities, or that authorize compulsory treatment of any kind to be performed on any persons with disabilities must be derogated.*
>
> (RCVMHS Final Report, Volume 4, page 372)

Any effectiveness in the use of compulsory treatment orders in the community was contested by Professor Lisa Brophy, Discipline Lead in Social Work and Social Policy at La Trobe University giving evidence in a personal capacity, pointed to conflicting results of studies and trials:

> *Randomised controlled trials have tended to focus on readmission to hospital and other outcomes and have not established evidence for the use of [Community Treatment*

> *Orders]. However, other studies, such as case-control studies that have followed people over time have found inconsistent and conflicting results. There is often speculation that the positive results are due to the increased contact with services that come with a [Community Treatment Order].*
>
> (RCVMHS Final Report, Volume 4, 374)

Considering evidence-based research, the Commission determined that despite some studies, it is difficult to distinguish any posited benefits for a person subject to an order:

> *'the sum of the evidence does not support their effectiveness in preventing relapse and readmission.*'
>
> (RCVMHS Final Report, Volume 4, page 375)

It noted significant research limitations to the two Victorian studies on CTO's that were conducted before the 2014 Mental Health Act changes, that suggested CTO's may avert further hospital admission. Conversely, it referred to finding in international research that indicated that CTO's '*did not prevent or shorten the length of hospital admission*', and furthermore, including a '*meta-analysis of the only three randomised controlled trials [that] suggested they may not lead to significant differences in readmission, social functioning or symptoms*' and an international review suggesting '*no difference*' compared to when people were '*accessing services voluntarily*'.

(RCVMHS Final Report, Volume 4, page 374-5)

Giving evidence in a personal capacity and as a representative for the Victorian Mental Illness Awareness Council, Dr Christopher Maylea, Senior Lecturer in Social Work at RMIT University considered that there is '*no overall benefit to compulsory treatment'* and that:

> *… obvious alternatives to compulsory treatment required, which would involve investment into Victoria's mental health services (particularly in community mental health services) and a re-focus on general themes of recovery-based treatment, early intervention and support, choice and the increased availability of peer work services and workers.*
>
> (RCVMHS Final Report, Volume 4, page 375)

Despite global evidence-based research, Australian professional advice, and the VRC acknowledgement of the 'systemic factors' leading to '*high rates of compulsory treatment use*' in Victoria, the VRC still concluded:

Given the limitations on human rights, the negative experience of compulsory treatment experienced by many consumers, and the contested evidence on its effectiveness when used in community settings, the Commission has formed the view that the Victorian Government should focus on reducing compulsory treatment.

(RCVMHS Final Report, Volume 4, page 375-6)

Further, it noted that the MHRT maintained CTO's for longer: when comparing duration of orders, the 'data indicates that the orders are often ended by an authorised psychiatrist earlier than the duration of the order made by the Tribunal', where '*25 percent of people are given 12-month Community Treatment Orders; however, only 14 per cent actually spend that long on the order*', where 40% of 'consecutive orders are longer than one year in duration'. The use of compulsory treatment varies across Victorian local districts, however is slightly higher than the national average for the proportion of involuntary acute hospital stays, (including forensic patients) and the period of involuntary separation. A review in 2016-17 indicated that the rate in Victoria was 76.4 per 100,000 people, 'significantly higher than other states and territories'. This rate has varied, in 2017-2018 the rate was 48.9, 55 in 2005, and 98.8 in 2012. This is high compared to NSW's rate of 48.1 (an increase to 50.4 in 2017-18), and the 2017-18 national average rate of 44. From this data, the VRC concluded that:

Based on the above data it is clear that the current Mental Health Act has not led to a reduction in the use or duration of compulsory treatment as envisaged. It is also clear that more than legislative change is required to reduce the use of compulsory treatment in the future.

(RCVMHS Final Report, Volume 4, page 381-5)

Despite the questionable efficacy and its potential harms, and the problems of service access and equity of quality care, it was realised that CTO's are used as gateways to service delivery.

Professor Brophy described concerns with using Community Treatment Orders in this way:

one of the concerns about [Community Treatment Orders] being a 'gateway' for guaranteed service delivery is the length of time that a person remains on a compulsory order, first in the inpatient unit and then in the community. This does not take into account the potential harms, such as loss of self-efficacy and stigma, that are being inflicted on the person as a result of being a compulsory patient

Members of the mental health workforce shared with the Commission that having the resources to engage meaningfully with consumers and develop therapeutic relationships would help reduce the use of compulsory treatment:

> *If there is sufficient time for treatment, there are many alternatives to compulsory treatment, such as voluntary treatment or working with people in a manner that maximises therapeutic alliance to identify what matters to the consumer. In an acute crisis situation, however, people often experience distress in a very short timeframe and have limited capacity to make choices that are safe*

… Dr Coventry told the Commission that compulsory treatment can be averted when treatment, care and support that matches consumers' needs and preferences can be accessed

(RCVMHS Final Report, Volume 4, page 387)

The personal story of Barb Birthisel, who was a member of the *Independent Mental Health Advocacy Consumer Advisory Group, has a Diploma in Community Services, and works as a disability support worker, intending to become a peer worker.* In distress due to family violence, a relationship breakdown and the subsequent child support issues, she captured the failures of ending up losing her job and in a psychiatric ward, and on compulsory medication treatment:

> *people need to be listened to and treated like a human being ... If someone had listened to me, I would have been fine ... They basically shut you down and shut you up.*
>
> *There should be places for people to go where they are having breakdowns. Mental health care should be taken out of hospitals so that these can be places of care and healing.*

(RCVMHS Final Report, Volume 4, page 388)

Are Compulsory Treatment Orders Antithetical to Personal Autonomy and Respect for the Consumer?

The VRC Report, as well as community and media responses to it, focus on the importance of mental health consumers and communities being at the centre of the design, delivery, monitoring and evaluation of mental health services. Do consumers have a right to say no to compulsory treatment orders? Should they have one if consumer control is central to the recommended reforms? This contradiction can not be reconciled with compulsory treatment orders.

'The Commission recognises that there is a tension between compulsory treatment and the strengths-based, collaborative care coordination approaches it has recommended.'

(RCVMHS Final Report, Volume 1, page 426)

The VRC recognises that:

'Where a consumer has a compulsory treatment order, the support provided will aim to have the consumer resume decision-making autonomy about their treatment, care and support.'

(RCVMHS Final Report, Volume 1, page 407)

'Care planning should promote autonomy and support decision making, including when consumers are subject to compulsory treatment orders.'

(RCVMHS Final Report, Volume 1, page 307)

But, 'While this is already a legal requirement in Victoria, aspirations to embed supported decision making into treatment, care and support have not been realised.'

(RCVMHS Final Report, Volume 1, page 426)

'Among consumers and carers consulted by the Commission, there was a strong perception that current Crisis Assessment and Treatment Teams are often less helpful than they should be; for example, they may ***focus on determining whether the person meets thresholds for compulsory treatment rather than helping with crisis resolution.'***

(RCVMHS Final Report, Volume 1, page 530)

'I believe that compulsory treatment,...causes many of the problems that it is supposed to remedy.' One community witness who has engaged in the system as a peer support worker.

(RCVMHS Final Report, Volume 1, page 595)

Over-medicalisation And Its Adverse Iatrogenic Health Risks, And Medication Alternatives Are Needed

Whether voluntary or involuntary treatment, there are high level of complaints about medication and concerns about its short and long term effects:

My family member was moved to a new antipsychotic, starting on a high dose, the resulting side effects included a heart rate of 180–200 which required beta-blockers, weight gain has now reached 50kg and smoking cigarettes was ignored/not managed which has now resulted in ulcers in her oesophagus. The side-effects are not managed, the medication is not reduced without family pushing to have it reviewed. My family member is no longer experiencing psychosis and this is considered a win and now she is left to the community on a [Disability Support Pension] with a very low ability to be a part of the community due to the side effects of the medication.

The need for expert pharmacological management and support for consumers, families, carers and supporters, to participate in decision-making around medications, is heightened by the fact that many consumers are on several different medications. As shown in Figure 7.4, consumers of public specialist mental health services were much more likely to be dispensed six or more scripts than other Victorians who were dispensed mental health-related scripts under the Pharmaceutical Benefits Scheme in 2017–18. High levels of medication, and the use of multiple medications, increases the chance of medication errors and adverse reactions.

(RCVMHS Final Report, Volume 1, page 395-6)

To ensure that health professionals work closely with consumers to understand the effects of medications, it may be necessary to mandate that health workers engage regularly with consumers to monitor and discuss with them the impacts of these medications. This happens, for example, in the use of the drug clozapine. A group of psychiatrists informed the Commission that clozapine is the 'gold standard' for treatment of schizophrenia when other medications have been unsuccessful. Their submission suggested that the drug improves outcomes and can prevent suicides in people who are described as having 'treatment resistant schizophrenia'. They considered that, as well as the properties of the medication itself, the superior outcomes associated with clozapine can be attributed to the fact that the impact of this medication must be closely monitored by health professionals:

> *Clozapine treatment requires monthly blood tests to monitor for neutropenia and this requires care coordination on an ongoing basis. Indeed patients receiving clozapine have reduced mortality and this is partially attributed to the benefits of the ongoing care coordination role ... The lifelong clozapine care coordination and monthly appointments likely help in a number of ways, including general support, addressing psychosocial issues, observing for early warning signs and relapse prevention, lifestyle checks, metabolic monitoring, coordination of appropriate medical interventions, liaison with primary care and family, management of side-effects, and monitoring overall adherence.*

The psychiatrists quoted above suggested that the level of ongoing monitoring and care coordination received by consumers taking clozapine should be offered to all consumers with 'enduring, and relapsing symptoms' regardless of the medication they are taking. They noted that medication should be one part of comprehensive programs that 'can support recovery, and promote employment, education, housing, relationships, and health'.

In its recent mental health inquiry, the Productivity Commission examined medication prescribing in some detail. The Royal Commission supports its findings and recommendations in this area, as reproduced below:

> *As a priority reform, clinicians offering mental health medication as treatment should be required to inform the consumer of the side effects prior to prescribing and offer alternative non-pharmaceutical treatment options. The clinical benefits of many mental health medications (particularly for conditions that are not severe) and the long-term physical and mental health outcomes for people who use them, are disputed, with severe side effects in some population subgroups and substantial overprescribing for others. More research focused in these areas, and uptake of its resulting lessons among treating clinicians, could generate significant improvements in mental healthcare treatment outcomes.*

The Australian Government should act to improve practitioners' training on medications and non-pharmacological interventions.

In Chapter 36: Research, innovation and system learning, the Commission presents its findings on the urgent need for new and better medications for mental illness but—equally critically—for research to identify interventions that reduce or eliminate the need for medication. In addition, the Commission considers that researchers should help identify the barriers to uptake of existing approaches that reduce medication needs.

(RCVMHS Final Report, Volume 1 page 398)

Over-representation Of Aboriginal & CALD People Under CTO's

International studies and the experience in Australia is that there is an over-representation of culturally diverse, marginalised and economically disadvantaged people treated compulsorily:

> *Aboriginal people are also over-represented in relation to compulsory treatment orders in comparison to the rest of the Victorian population, making up approximately three percent of clients placed on compulsory treatment orders.*
>
> (Royal Commission Report, Volume 3, page 145)

The over-representation of Aboriginal people on compulsory treatment orders should be understood in the context of the effects of '(inter)generational trauma, racism, discrimination, marginalisation and disadvantage' on the health and wellbeing of Aboriginal people.[42] While being less likely to access mental health services, people from refugee and migrant backgrounds are more likely than the general population to be admitted to inpatient units and are over-represented on compulsory treatment orders, making up 23 percent of active compulsory treatment consumers in Victoria. [43]

The Commission recounted a personal story of Tommy - who was put on a compulsory treatment order when he was 20 years old, and about his later experience in Thomas Embling - a forensic mental health hospital in Victoria:

> *I wish I had access to Thomas Embling without committing an offence. If there were a Thomas Embling in the community, for the public before you commit an offence, I think that would be a real positive*.
>
> (Royal Commission Report, Volume 2, pages 386-387)

This is worsened by the negative impact that arises from witnessing compulsory treatment and/or restrictive practices, whether staff, or family or friends of those directly affected, and these wider effects are often either not seen, or addressed, and can become intergenerational, as is often suffered throughout first nations communities (Royal Commission Report, Volume 2, page 377).

Additionally, the use of restrictive practices can adversely affect the therapeutic relationship between consumer and clinician. These experiences of trauma and restraumatisaiton can also make the consumer reluctant to seek help again, leaving them at risk during future periods of distress (Royal Commission Report, Volume 4, 299).

In Victoria's under-resourced and crisis-driven system, a risk management lens often colours the content and application of mental health laws. For example, while compulsory treatment was intended to be reduced under the Mental Health Act, it is often used as the default approach and similarly, supported

[42] (Royal Commission Report) Volume 3, page 145.

[43] (Royal Commission Report) Volume 3, page 214.

decision making practices are not commonplace—despite requirements contained within the Act. For consumers, this has adverse consequences, such as severe limitations on human rights, and increased stigma and discrimination that may flow from being placed on compulsory treatment orders (Royal Commission Report, Volume 4, page 13).

The narrow focus of the Mental Health Act on compulsory treatment can contribute to the dominance of a biomedical model of care. This model preferences the views of mental health practitioners over those of consumers, focuses on *'deficits'* that need to be fixed or managed by medication, and is moulded around a flawed expectation that the system is responsible for managing short-term risk management tools of medication, hospitals and the Mental Health Act, rather than emphasising recovery (Royal Commission Report, Volume 4, page 21).

Ms Rachel Bateman, a witness, stated:

> *'A huge barrier to person-centred care is… compulsory treatment…'*
>
> (Royal Commission Report, Volume 4, page 25)

Ms Elizabeth Porter, a witness, spoke about the penalising distress and confusion she experienced:

> *'having compulsory treatment was a feeling of being incarcerated.'*
>
> (Royal Commission Report, Volume 4, page 25)

Professor Neil Rees, the former president of both the Mental Health Review Board and the Victorian Law Reform Commission, criticised the current mental health laws, and the 'dominance of a biomedical model of care' as 'deficient' was also to blame:

> *The raison d'être* [main reason] *for existing mental health laws is to permit compulsory treatment and detention in some circumstances.*
>
> (Royal Commission Report, Volume 4, page 21)

Far from the long standing ideological practice of servicing as 'person-centred', these restrictive practices were overly oriented to acute medication management, the current system led by psychiatry was criticised in various ways, and the urge for reforms based on a 'paradigm shift' was repeatedly made:

> *We need a paradigm shift where the law and mental health services are driven on the presumption that people with mental health challenges are capable of managing their own mental health. A presumption of recovery.*

(Royal Commission Report, Volume 4, page 21)

Victoria Legal Aid's Your Story, Your Say project shared the views of Susan Mahomet, who said that little weight was given to consumer opinions and preferences.

> *Psychiatrists and mental health services don't listen to you. If I had a meeting now, the psychiatrist would have already made up their mind, because they had read the notes… Meeting with you is just a formality.*

(Royal Commission Report, Volume 4, page 21)

The Commission examines different stakeholder's perspectives on the inadequacy of the Mental Health Act. Whilst it was suggested that the poor implementation and poor understanding of compulsory treatment criteria was one of the sources of the issue, many others argued that legislation enabling compulsory treatment was in itself a breach of human rights: 'The treatment criteria for compulsory treatment are not well understood or correctly applied by decision makers' (Royal Commission Report, Volume 4, page 28).

Others argue, however, that the continued existence of laws that permit compulsory treatment and substituted decision making in any form is fundamentally incompatible with human rights (Royal Commission Report, Volume 4, page 29).

Instead of treatment being focused on the care and recovery of consumers, it is centred around whether a consumer meets the criteria for compulsory order treatment, as stated in:

> *The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the Act apply to a person.* (Royal Commission Report, Volume 4, page 253)

Mental health treatment that does not consider the personal autonomy and needs of the consumer can lead to experiences with serious physical and psychological consequences:

> *Many consumers can experience harms as a result of compulsory treatment, or from being secluded or restrained during admission to a mental health inpatient unit. This can include both physical harms and psychological trauma.* (Royal Commission Report, Volume 4, page 261)

> *Consumers told the Commission of these harms: The compulsory treatment order made it hard for me to experience good mental health. I felt as if my basic human rights were taken away from me. (Royal Commission Report, Volume 4, page 261)*

Respecting Consumer's 'Dignity Of Risk

Failures in 'respecting consumers' dignity of risk' is one of the principles in the Mental Health Act that compromises person's choices and preferences: *that 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk*'.The intention of the Act is for services to support people and respect their dignity of risk, including when they are subject to compulsory treatment. However, a range of factors affect consumers' dignity of risk being respected:

> *Community-wide stigma and discrimination, and the expectations placed by society on the mental health workforce conflict with goals of affording consumers' the dignity of risk, respecting consumer preferences and measures to support consumers to make their own decisions.'*
>
> (RCVMHS Final Report, Volume 4, page 392)

One of the principles in the Mental Health Act is that 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk'. The intention of the Act is for services to support people and respect their dignity of risk, including when they are subject to compulsory treatment. However, as outlined previously, a range of factors affect consumers' dignity of risk being respected.

Mr Kelly explained the dignity of risk as 'allowing a person to make their own decision which may well be against the practitioner's better judgement'. This is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'.

Ms Porter told the Commission about the importance of being supported to make decisions that may involve risks and the gains she has made personally by doing so:

For me, personally, the dignity of risk is why I am alive. Simply put, people with mental health conditions should be able to make informed decisions to take risks, take responsibility for our choices, and come to terms with the effects of our actions. The dignity of risk is about both not being prevented from having agency; and being enabled to exercise agency. Recently, I decided to try to come off my medication. I made this decision for various reasons, including the debilitating side effects my medication has had on me ... My doctor and I weighed up the potential consequences including psychosis, debilitating depression and death, versus the long term health deficits, major loss of meaning in life, not wanting to live and also possible death. My doctor, who has an understanding of agency and risk, was willing to support my choice and go through this

with me—to support me over a year coming off my medication ... Initially, it had positive aspects ... However as the year progressed, I became increasingly manic and depressed. But what was important was that ... my doctor was there to support me; who I could call and ask for help ... So having a doctor who respected my choice made it possible for me to live.

Associate Professor Simon Stafrace, Chief Adviser at Mental Health Reform Victoria, told the Commission in a personal capacity that there is a tension between the dignity of risk and the expectations of harm minimisation on the mental health system:

Competing commitments are evident when clinicians strive to respect the dignity of risk and limit restrictive treatments, and then choose to deploy coercive treatment to minimise the possibility patients could be harmed by their own actions or as a result of accidental neglect during acute episodes of illness. Risk aversion may be driven by the fear or lived experience of being publicly sanctioned by the coroner, investigated by multiple oversight bodies in relation to the same issue, or sued for damages in civil courts ... I have witnessed clinicians being subjected to all these outcomes ...178

The Victorian Branch of the Royal Australian College of Psychiatrists supports the following approach to the dignity of risk within mental health practice:

a balanced clinical approach that integrates and respects the dignity of risk alongside issues of safety for the individual and the community. This clinical approach should consider the right for those with capacity to make decisions that clinicians and those in a support role may not agree with.179

Community-wide stigma and discrimination, and the expectations placed by society on the mental health workforce conflict with goals of affording consumers' the dignity of risk, respecting consumer preferences and measures to support consumers to make their own decisions.

(RCVMHS Final Report, Volume 4, page 392)

Averting Stigma And Discrimination - Becoming ‘Consumer-centred’ Via Consumer Leadership And Participation, And Protecting The Dignity And Rights Of Persons

In order for mental health treatment to become recovery-based rather than overly reliant on compulsory treatment, the Commission includes key suggestions made by witnesses, professionals and council members:

Professor Richard Newton, Clinical Director of Peninsula Mental Health Service, told the Commission that cultural change is needed to reduce compulsory treatment, and one way to

achieve this is by delivering services that are more consumer-centred. (RCVMHS Final Report, Volume 4, page 32)

The Victorian Mental Illness Awareness Council proposed that 'consumer leadership and participation must be core to all regulatory and oversight processes' because consumers can bring further insight to the issues being regulated compared with people who have not experienced compulsory mental health treatment. (RCVMHS Final Report, Volume 4, page 232)

Ms Erandathie Jayakody, a witness before the Commission, said: A law that authorises a mental health service provider to administer compulsory treatment and engage in restrictive practices needs a higher degree of accountability to protect the dignity and rights of persons subject to compulsory treatment. (RCVMHS Final Report, Volume 4, page 262)

A key step to implementing cultural change, consumer leadership and a higher degree of accountability as highlighted by the Commission, is the use of databases. Data can be used to record the demographics of consumers as well as the outcomes and personal experiences of mental health treatments. It is critical to service design, evaluation and consumer choice, and a key part of accountability however, it is currently underused:

Victoria Legal Aid told the Commission: There is very limited publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, and their geographical location, age, gender, cultural background, type and length of order, and complaints. (RCVMHS Final Report, Volume 4, page 262)

Using consumer feedback and data on current practices and outcomes (including benchmarks with similar services) should be used to design and update improvement efforts. (RCVMHS Final Report, Volume 4, page 267)

To further improve the outcomes of mental health treatment, the Commission also recommends a number of other changes relating to workforce training and collaboration with those who have lived experience with mental illness or distress. The Commission highlights how these changes ensure treatment is more consumer-focused and considerate:

Consumers in particular, but also families, carers and supporters, should inform all aspects of the independent oversight and complaint-handling functions. The staffing of these functions should include dedicated lived experience roles, including senior operational positions.

Include people with lived experience of mental illness or psychological distress in the design and implementation of improvement projects. (RCVMHS Final Report, Volume 4, page 267)

Broader changes to models of care, workforce training and interactions between staff and consumers are also important. Dr Coventry told the Commission: … 'Clinicians must respond empathetically to people's distress, hear their fears and concerns, and meet their practical, social, psychological and physical needs.' (RCVMHS Final Report, Volume 4, page 264)

The Commission also mentions several programs including *Safewards* and *Safer Care Victoria* that could be implemented to improve mental health treatment outcomes:

- *Safewards* provides a range of interventions to help provide a sense of safety and mutual support for staff and consumers. Since 2014 Victorian public acute mental health inpatient units have implemented the Safewards model. (RCVMHS Final Report, Volume 4, page 264)
- In 2018 *Safer Care Victoria* formed a strategic partnership with the *Institute for Healthcare Improvement* to increase use of the model and strengthen service capability across Victoria.(RCVMHS Final Report, Volume 4, page 259)
- As part of its partnership with the *Institute of Healthcare Improvement, Safer Care Victoria* has been building interest and skills in improvement science, bringing together collaborative teams to use quality improvement methodologies to achieve a specific, measurable goal. (RCVMHS Final Report Volume 4, page 266)
- The Commission considers that the mental health system requires a dedicated mechanism for oversight, rather than relying only on existing regulatory and oversight arrangements for either health or community services. (RCVMHS Final Report Volume 4, page 278)
- The *World Psychiatric Association*'s position statement describes how a person's rights are denied when they are subject to compulsory treatment: Of central concern is the protection of human rights, and the extent to which coercive interventions violate these. These include rights to: liberty; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life. (RCVMHS Final Report Volume 4, page 363)

The Commission gathered information and opinions from a wide range of sources:

- *In Victoria, the Mental Health Act 2014 (Vic) provides the legal framework for compulsory treatment. Ms Cath Roper, Consumer Academic for the Centre for Psychiatric Nursing at the University of Melbourne, told the Commission, however, that the Act fails to promote human rights: The legislation does not promote human rights—it actually tells us where it is legal to breach them. That legislative approval papers over the reality of those breaches, because it declares that the treatment is necessary.* (RCVMHS Final Report, Volume 4, page 263)
- *The Commission considers that using compulsory treatment only as a last resort will be a critical indicator of the success of its vision for a redesigned mental health and wellbeing system. To*

deliver this vision and reduce the use of compulsory treatment in Victoria, community-wide stigma and discrimination must also be confronted. (RCVMHS Final Report, Volume 4, page 364)

- *Associate Professor Ruth Vine, who said that 'leaving a person untreated, tormented by auditory hallucinations and delusions and at great risk of harm, is not compatible with international conventions on human rights'.* (RCVMHS Final Report, Volume 4, page 369)
- *At the time the current Mental Health Act was introduced, it was argued that the limits on rights posed by compulsory treatment were needed because 'people may suffer unnecessarily and experience serious harm or deterioration in their mental health or may harm another person'. These limits were deemed reasonable and proportionate for a range of reasons, including that only a small number of people would be subject to compulsory treatment; that safeguards such as advance statements and nominated persons provided some protection for consumers; and that oversight mechanisms were in place to monitor the use of compulsory treatment.* (RCVMHS Final Report, Volume 4, page 369)
- *Human rights obligations under Victorian and international law apply in relation to compulsory treatment. This means taking into account the full range of people's needs and rights, which include the right to the highest attainable standard of health, to promote respect for the inherent dignity of people, and to remove barriers that hinder full and effective participation in society on an equal basis with others.* (RCVMHS Final Report, Volume 4, page 370)
- *Police officers apprehending a person to take them to a hospital causing distress ; consumers and advocates called for more focus on, and access to, non-coercive alternatives, and some advocated for compulsory treatment to be abolished.* (RCVMHS Final Report, Volume 4, page 371)
- *The Commission contends that these negative experiences and the traumatic effects of compulsory treatment make it necessary to reduce the use of compulsory treatment. This will involve expanding the role and reach of services to offer different voluntary methods of treatment, care and support, in line with consumers' needs and preferences.* (RCVMHS Final Report, Volume 4, page 371)
- *Mr Peter Kelly, Director of Operations at NorthWestern Mental Health, stated that 'compulsory treatment is a serious imposition on an individual's freedom of choice and should only be used in the smallest number of cases and for the shortest period of time'.* (RCVMHS Final Report, Volume 4, page 374)
- *Dr Christopher Maylea; no overall benefit to compulsory treatment. Dr Maylea highlighted that there are: obvious alternatives to compulsory treatment required, which would involve investment into Victoria's mental health services (particularly in community mental health services) and a re-focus on general themes of recovery-based treatment, early intervention and support, choice and*

the increased availability of peer work services and workers. (RCVMHS Final Report, Volume 4, page 375)

- *Given the limitations on human rights, the negative experience of compulsory treatment experienced by many consumers, and the contested evidence on its effectiveness when used in community settings, the Commission has formed the view that the Victorian Government should focus on reducing compulsory treatment. This includes expanding non-coercive alternatives and ensuring diverse, well-resourced community-based mental health and wellbeing services are readily available. in Chapter 6: The pillars of the new service system—community-based mental health and wellbeing services.* (RCVMHS Final Report, Volume 4, page 375)
- *Since the introduction of the Mental Health Act, the number of compulsory assessment and treatment orders made across all three stages has continued to rise* (RCVMHS Final Report, Volume 4, page 377)
- *Compulsory treatment use is not consistent across Victoria, neither in the average duration nor the rates of compulsory assessment and treatment. The duration of Treatment Orders for adults is longer in metropolitan Melbourne than in regional Victoria.* (RCVMHS Final Report, Volume 4, page 382)
- *A review of the rates of Community Treatment Order use in 2016–17 indicated that Victorians were subject to Community Treatment Orders at higher rates per population than people in New South Wales, Queensland and Western Australia.* (RCVMHS Final Report, Volume 4, page 384)
- *In terms of access to services, it is estimated that, in 2019–20, active adult clients of public mental health services received about 5 percent of their community contact hours from a consultant psychiatrist.144 For those adults who did receive community mental health services from a consultant psychiatrist in 2019–20, the average total service hours per client was 21.5 hours. Indicates deficiencies in access to community-based mental health services. The Victorian Government's submission acknowledged that consumers of Victoria's community-based mental health services receive a less intense service offering than most of their counterparts in other Australian states and territories. the current Mental Health Act has not led to a reduction in the use or duration of compulsory treatment as envisaged. It is also clear that more than legislative change is required to reduce the use of compulsory treatment in the future.* (RCVMHS Final Report, Volume 4, page 385)
- *Under-resourcing of the mental health system has led to a reliance on a crisis-driven model of care. Scarce resources have meant that public mental health services have had little choice but to concentrate the delivery of services on crisis responses and acute inpatient services. This has made it difficult to focus on early intervention and recovery through community-based mental health services, which are approaches that would help to avoid crisis and reduce compulsory treatment use.* (RCVMHS Final Report, Volume 4, page 386)

- *Ms Anna Wilson, a carer and witness before the Commission, reflected on the 'overloaded and under-resourced workforce', telling the Commission that early discharge from services before clinicians build rapport with the consumer 'means that the only way to get access to support is through a treatment order, because under this they have to receive help'.* (RCVMHS Final Report Volume 4, page 386)
- *One of the concerns about [Community Treatment Orders] being a 'gateway' for guaranteed service delivery is the length of time that a person remains on a compulsory order, first in the inpatient unit and then in the community. This does not take into account the potential harms, such as loss of self-efficacy and stigma, that are being inflicted on the person as a result of being a compulsory patient.* (RCVMHS Final Report, Volume 4, page 387)
- *Better crisis responses including alternatives to emergency departments, with more staff with lived experience.* (RCVMHS Final Report, Volume 4, page 389)
- *Mental health workers working in a system that doesn't support them to deliver the appropriate service - difficult expectations placed on them. Reliance on CTO even though it conflicts with principles of recovery-oriented practice (e.g. personal autonomy) because they feel like they will be blamed if harm occurs to the patient.* (RCVMHS Final Report, Volume 4, page 390)
- *Dr Anna Arstein-Kerslake and Dr Yvette Maker: Health care professionals responsible for managing risk - not taking into account the will and preferences of a person with psychosocial disability.* (RCVMHS Final Report, Volume 4, page 391)
- *The Commission has been told that to reduce the use of compulsory treatment, a system that enables consumers and the mental health workforce to connect in a way that 'maximises therapeutic alliance to identify what matters to the consumer' is required.*[173] *But these practices do not seem compatible with the community expectations of managing risk that are placed on the workforce. It is apparent that an increasingly risk-averse society that arbitrarily holds individual clinicians accountable for system failures has contributed to the high rates of compulsory treatment. Mental Health Act: 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.' Mr Kelly explained the dignity of risk as 'allowing a person to make their own decision which may well be against the practitioner's better judgement'. This is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'. Mental Health Act: 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.' Mr Kelly explained the dignity of risk as 'allowing a person to make their own decision which may well be against the practitioner's better judgement'. This is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'.* (RCVMHS Final Report, Volume 4, page 392)

- *Consumers unaware of their rights to non-legal advocacy, legal representation and safeguards such as advance statements and nominated persons. Need to Reduce the power imbalance between consumers and clinicians.* (RCVMHS Final Report, Volume 4, page 393)
- *In an edition of Public Health Reviews, Dr Soumitra Pathare and Laura Shields explained that supported decision making can consist of organisations, networks, provisions or agreements that aim to assist a person to make and communicate decisions.* (RCVMHS Final Report Volume 4, page 393)
- *Victorian Mental Illness Awareness Council: When faced with such restrictions it is vital that consumers receive appropriate advocacy, either through legal representation or through an independent advocate who can provide supported decision-making that is free and confidential.* (RCVMHS Final Report, Volume 4, page 396)
- *In 2018–19 consumers were legally represented in only 13 percent of hearings. This contrasts with legal representation rates in hearings before the New South Wales Mental Health Tribunal, where legal representation was provided in 83 percent of hearings in 2018–19. Funding limitations are a major reason for Victoria's low representation rate.* (RCVMHS Final Report, Volume 4 page 397)
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- *A study that looked at international research relating to Community Treatment Orders indicated that these orders did not prevent or shorten the length of hospital admission. (Canberra Times, Mental Illness: The Health Crisis We're Happy to Turn a Blind Eye To, 29 November 2017)* (RCVMHS Final Report, Volume 4, page 372)

- *A meta-analysis of the only three randomised controlled trials related to Community Treatment Orders to date suggested they may not lead to significant differences in readmission, social functioning or symptoms. (Banyule Community Health, Submission to the RCVMHS: SUB.2000.0001.0501, 2019, p. 8.)* (RCVMHS Final Report, Volume 4, page 374)
- *An international review suggested there is no difference in service use, social functioning or quality of life between people on Community Treatment Orders and those accessing services voluntarily (The Royal Australian and New Zealand College of Psychiatrists , p. 29 citing Oliver D (2018) Moral Distress in Hospital doctors, British Medical Journal 360.)* (RCVMHS Final Report, Volume 4, page 375)

Reducing The Use And Duration Of Use Of Compulsory Treatment - A Last Resort

Volume 5: Transforming the system - innovation and implementation

- Rights and interests of consumers: the Commission's recommendations make the rights of consumers paramount. Services will be required to significantly reduce the use of compulsory treatment...Volume 5 page 182
- Advocacy organisations and groups are increasingly using digital technologies to improve people's understanding of their rights through the interactive provision of support tools and resources. For example, Independent Mental Health Advocacy has co-produced a self-help tool for people who want information and support to exercise their rights when they are receiving compulsory treatment. Volume 5 page 20
- online platforms provide a unique opportunity to engage with people early and to help them access the right treatment, care and support.Volume 5 page 20

Compulsory Treatment was recontextualised as 'service failure' and why these failures occur was explained and addressed in various ways. Replacing a crisis driven response system, an over medicalisation or reliance on a clinical paradigm focussed on the absence of symptoms of illness rather than on supporting consumer decision making and focussing on health and wellbeing. Concerns have been expressed that the current service offering is overly focused on prescribing medication and that it fails to respond to a person's preferences or their broader needs:

> *People have said there is a lack of effective wellbeing supports or approaches that respond to experiences of trauma or recovery-based responses. Ms Julie Dempsey, a witness before the Commission, explained:*

Current psychiatric units were set up as attachments to mainstream hospitals as a move to integrate back into wider society, away from the isolation of the old asylums. However, what this has achieved is an intensification of the medical model at the cost of real person-centred recovery.

(RCVMHS Final Report, Volume 1, page 194)

The dominance of a clinical paradigm in the current service offering is also considered at odds with Aboriginal cultural understandings of mental health, which are based on beliefs about the inextricable connections between a person's physical, emotional and spiritual wellbeing, and their community and the environment. As highlighted in the Ways Forward report, for Aboriginal people '[h]ealth does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community.

(RCVMHS Final Report, Volume 1, page 194)

Structural problems, such as major supply problems and a crisis-driven approach, have adversely affected the workforce's ability to work effectively and deliver the types of services people seek. Members of the current workforce often find themselves trying to do their best in a system that constrains them. As the Royal Australian and New Zealand College of Psychiatrists highlighted, '[p]sychiatrists and other mental health workers, are facing moral distress: a desire and knowledge to do the right thing, but system constraints make it impossible to do so.'

(RCVMHS Final Report, Volume 1, page 194)

The Case of 'Rachel Bateman' exemplified that consumers are not getting what they want from the current system, with very little access to other therapeutic approaches - only medication offered:

Rachel has been involved with the mental health system since she was 14 years old, with several admissions to inpatient units. Rachel felt that her local area mental health service was not offering her anything more than medication, with little access to different therapeutic approaches.*

> *In my experience, clinicians within [area mental health services] do not view their role as providing therapy ... They just keep saying, 'That's not what we're here for. Go and get therapy elsewhere'.*

*Rachel feels that while 'the phrase "*person-centred care*" is thrown around a lot' it is not embedded in mental health services.*

> *If organisations were truly person-centred, they'd be set up in a way that delivers the support that people need at various parts of their recovery journey.*
>
> (RCVMHS Final Report, Volume 1, page 400)

The Commission heard that area mental health services have become overly reliant on a medical model of care and a generic case management approach that does not empower the multidisciplinary workforce to help consumers, families, carers and supporters, using discipline-specific skills and expertise.

Consequently, many evidence-based forms of treatment, care and support are not readily available in the public mental health system. Professor Patrick McGorry AO, Executive Director, Orygen and Professor of Youth Mental Health, University of Melbourne, told the Commission in his personal capacity:

> *I could give about ten different examples of treatments that I've seen developed in my time in psychiatry, new treatments, drug therapies and also psycho-social treatments, including many that we've developed here in Victoria, that are simply not available to people; they're not what the system delivers. The system delivers this very basic generic case management and risk management system; it doesn't deliver all the things that we already have at our disposal in an effective way.*
>
> (RCVMHS Final Report, Volume 1, page 379)

The issue of medical treatments has been the basis of a high number of complaints received by the Mental Health Complaints Commissioner, as was addressed in Volume 1, Chapter 7: 'Integrated treatment, care and support in the community for adults and older adults'. The Commission stated that there are 'frequent misgivings about medication side effects' however it was alert to the high number - 19% in 2017-18- of consumer complaints and concerns:

> *Most medical treatments used in mental health services are 'psychotropic' medications to ease the symptoms of mental illness or psychological distress (for example, antipsychotic medication and anti-anxiolytics to help people experiencing high levels of anxiety)*

However, considerable evidence before the Commission indicates a need for better prescribing and medication management and monitoring practices in Victoria's mental health and wellbeing system. This is consistent with the high number of complaints about medication prescribing—in 2017–18, complaints about medication constituted 19 per cent of new submissions to the Mental Health Complaints Commissioner.

… According to the Mental Health Complaints Commissioner, a common concern is that mental health services do not adequately consider or respond to consumers' concerns about medication side effects. This was also a strong theme in evidence received by the Commission. The following quote is illustrative:

> *There needs to be more [doctor] awareness of bad side effects and the [doctors] need to listen if a person has a complaint about the medication, rather than the [doctors] making out as though the 'bad side effects' are part of the person's mental condition. There needs to be more awareness of the rights of people. More advertising on wards regarding how someone has rights and how to get support and [a] second opinion if desired.*

….Many consumers spoke to the Commission about these 'bad side effects.' For example, witness Mr Dave Peters said:

> *[The] physical health of people with mental illness can be affected by the medications they take for their mental illness. In addition to the significant impacts on physical health and life expectancy ... certain medications can have a terrible impact on oral health. In addition, the sedation effects of some medications can cause the people taking them to suffer from apathy and disengagement from life. That is something that I still struggle with.*

Apart from the medication side effects noted by Mr Peters, many psychotropic medications are known to dramatically increase appetite. This can result in physical health challenges such as excessive weight gain and related health problems.

Given the potentially serious nature of these side effects, the Commission is concerned by evidence of poor prescribing practices, including a lack of information about the medications given by clinicians administering the products.

(RCVMHS Final Report, Volume 1, page 395-396)

Recommendation 56: Supporting Consumers to Exercise Their Rights

The evidence and findings supporting this recommendation are noted and indexed below.

The Royal Commission recommends that the Victorian Government:

- Promote, protect and ensure the right of people living with mental illness or psychological distress to the enjoyment of the highest attainable standard of mental health and wellbeing without discrimination.
- Include a legislative provision in the new Mental Health and Wellbeing Act (refer to recommendation 42) enabling an opt-out model of access to non-legal advocacy services for consumers who are subject to or at risk of compulsory treatment.
- Increase access to legal representation for consumers who appear before the Mental Health Tribunal, particularly when consecutive compulsory treatment orders in the community are being sought.
- Align mental health laws over time with other decision-making laws with a view to promoting supported decision-making principles and practices.

(Royal Commission Report, Volume 5, page 283)

Rights And Responsibilities To Consumers

The fundamental basis of this new 'architecture' of reform - changing the mental health act legislation, refocusing away from clinical/medical paradigm to one that is consumer/person centred, at all levels. The VRC has articulated that not only consumer voice, but participation, workers and leadership occur within all aspects of co-design of the new system, consumer leadership and representation within the entities managing and responsible for the oversight and management reforms, the steady reduction to the elimination of restrictive interventions/practices, the new models of practice that are yet to emerge.

This remains a problem in how compulsory treatment -even as a last resort - is to be resolved in relation to consumer rights and responsibilities being upheld. However the overall thrust is clearly intended to focus on protecting and supporting consumer rights, ensuring informed consent, promoting least restrictive practices, and including consumer-response outcome measures as part of the evaluation of service provision and funding. Emphasis is directed to achieving this :

Dignity and respect

All consumers have the right to treatment that respects their dignity and privacy.

Legislation

The service provider should ensure they have access to and comply with legislation, acts and guidelines related to their service. There are many sources for this information. Current information on applicable legislation, acts and guidelines, such as an extract from the Privacy Act or fact sheets are available from Health service providers page on the Office of the Australian Information Commissioner website (www.privacy.gov.au)

Informed Consent

VRC defined this:
Informed consent means that a person:

- Is provided with appropriate and adequate information.
- Is capable of understanding the nature of the information and the consequences of a decision made in relation to this information.
- Can freely make decisions without unfair pressure or influence from others.

Privacy and confidentiality

- Confidentiality of personal information should be in accordance with Commonwealth, state and territory legislation.
- Involvement in care.

Evidence that this criterion is met could include:

- Consumers being given information about their rights and their own role in recovery goal setting, individual service planning and review.
- Documenting the consumer's active participation in developing their recovery goals and individual support plans.
- Review arrangements demonstrating how the consumer was actively involved in the process.
- Consumer feedback arrangement.

- *Mental Health Act: 'persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.' Mr Kelly explained the dignity of risk as 'allowing a person to make their own decision which may well be against the practitioner's better judgement'. This is consistent with recovery-oriented practice and involves 'optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk'.* (RCVMHS Final Report, Volume 4, page 392)
- *Consumers unaware of their rights to non-legal advocacy, legal representation and safeguards such as advance statements and nominated persons. Need to Reduce the power imbalance between consumers and clinicians* (RCVMHS Final Report, Volume 4, page 393)
- *In an edition of Public Health Reviews, Dr Soumitra Pathare and Laura Shields explained that supported decision making can consist of organisations, networks, provisions or agreements that aim to assist a person to make and communicate decisions.* (RCVMHS Final Report, Volume 4, page 393)
- *Victorian Mental Illness Awareness Council: When faced with such restrictions it is vital that consumers receive appropriate advocacy, either through legal representation or through an independent advocate who can provide supported decision-making that is free and confidential.* (RCVMHS Final Report, Volume 4, page 396)
- *In 2018–19 consumers were legally represented in only 13 percent of hearings. This contrasts with legal representation rates in hearings before the New South Wales Mental Health Tribunal, where legal representation was provided in 83 percent of hearings in 2018–19. Funding limitations are a major reason for Victoria's low representation rate.* (RCVMHS Final Report, Volume 4, page 397)

Secure Facility And Long Rehabilitation Processes, As Least Restrictive Options

There are instances when a secure facility is the least restrictive choice, for forensic patients. A 'security patient' was defined as:

> *'A prisoner who is placed on an order under the Mental Health Act 2014 (Vic) or the Sentencing Act 1991 (Vic) and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).'* (RCVMHS Final Report, Volume 1, page 618)

Forensicare identified that current arrangements do not include a 'consistent process to identify, assess or support this group of vulnerable prisoners', and there is 'a lack of available services both within prison and in the community (RCVMHS Final Report, Volume 1, page 209).

A Forensic patient was defined as:

A person under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) through an order of a court and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital). (RCVMHS Final Report, Volume 1, page 661)

Professor Richard Newton, Clinical Director of Peninsula mental health service, emphasised that in order to operate more effectively, secure extended care units need to make more beds available, including to support people with different security needs:

'they cannot access support because there are not enough SECU beds. To operate more effectively, SECU services need to make more beds available, including secure and open beds. Very few consumers overall need SECU beds, but those who do need stabilisation and security.' (RCVMHS Final Report, Volume 1, page 618)

In his evidence, Dr Coventry elaborated on the factors that have detracted from the therapeutic nature and safety of existing care options. Specifically, he noted growing numbers of consumers in acute inpatient units with 'limited rehabilitation options',185 who may not appropriately be supported in these inpatient settings or secure extended care units.186 He also indicated that models of care designed to support people with subacute needs are not as effective in instances of higher complexity needs.187 In some cases, more time-extended rehabilitation options are required, but they may not be available.188 Civil or non-forensic consumers requiring high-intensity support in a high-secure, safe environment at Thomas Embling Hospital cannot be admitted because of bed constraints. (RCVMHS Final Report, Volume 1, page 618)

Professor David Copolov AO, Professor of Psychiatry at Monash University also commented about the highest intensity needs, and similar concerns exist in relation to community care units. Associate Professor Vine noted that the community care unit environment 'leaves a lot to be desired'. Also, Dr Coventry suggested that extended rehabilitation models of care must be reformed to address the sometimes very different requirements of people with mental illness and highly complex support needs. He also emphasised the need for greater specialisation and flexible streaming capacity within these settings to ensure consumers have access to treatment, care and support that is specifically tailored to their individual support needs at any given time. This included long-term forensic patients:

Models of care also need to be supported by investment into specialised training and supervision for the workforce to provide evidence-based treatment for complex needs and intensive psychosocial rehabilitation. Without a streamed approach, consumers with specific needs requiring specialist input are cared for alongside others with very different needs. This

includes small numbers of young people with severe developmental disorders such as autism spectrum disorders, as well as involvement with child protection and youth justice; long-term forensic patients needing slow-stream rehabilitation into the community; adults with various conditions and risk of severe violence towards other consumers, visitors and staff; and small numbers of people who will be unlikely to be able to transition to less restrictive community care and need long term care options.

In addition to acute hospital bed-based service, access to a range of care is desirable to maximise access to the least restrictive option - of 'increased acuity and complexity of support based needs'. It is beneficial for our mental health system to have access to a range of adult bed-based services and alternatives, such as detailed in the Final Report, Volume 1, Chapter 10, page 588. These bed-based services range include subacute community and non-acute long stays, transitional support units and extended care units offering a secure environment. The Commission detailed a variety of highly specialised state-wide services, such as The Box Hill Hospital addition medication unit, that offers 'service offers crisis support and withdrawal management, as well as treatment for co-occurring mental or physical illness'. It included the forensic mental health services offered at Thomas embling Hospital to 'provide treatment, care and support to people living with mental illness who have been transferred from prison, those who have been ordered by courts to be detained for psychiatric assessment and treatment and, in very limited circumstances, people who have been referred by area mental health services'.

VRC Report, Volume 1, Chapter 10 also proposed for the expansion of Thomas Embling Hospital for:

'*new community rehabilitation and intensive rehabilitation models of care will support the rehabilitation of many people living with the highest intensity support needs. In some instances, however, an alternative and more secure form of extended bed-based rehabilitation is needed'*. *Historically, Thomas Embling Hospital was able to provide treatment, care and support to civil consumers with highly complex support needs, including increased security needs. Bed availability constraints no longer allow for this. The Victorian Institute of Forensic Mental Health (Forensicare) has acknowledged this capacity has reduced as the number of longer-term forensic consumers has increased. Distinguished Professor James Ogloff AM, Executive Director at Forensicare and Distinguished Professor of the Centre for Forensic Behavioural Sciences at Swinburne University, also informed the Commission that 'the capacity to assist the broader area mental health services' by admitting some patients with high-intensity needs has 'been lost'.*

As Dr Coventry described, this has not only prevented forensic patients and security patients (transferred from the prison system) from being admitted to Thomas Embling Hospital, it

has also prevented civil consumers, who cannot safely be accommodated in adult acute or secure extended care unit settings, from being admitted.

Distinguished Professor Ogloff also described the potential for locating a secure extended care unit within Thomas Embling Hospital. His evidence was that this would allow movement of consumers within the hospital, in addition to providing them with access to Thomas Embling Hospital's facilities and education programs (which are otherwise usually not available, for example, in current secure extended care units).

To respond to the needs identified by Dr Coventry, and consistent with Distinguished Professor Ogloff's evidence, the Commission has recommended that the new Victorian extended rehabilitation pathway include increased civil capacity at Thomas Embling Hospital. The expanded capacity will ensure appropriate treatment, care and support is provided for the small group of people who require high-intensity supports that cannot be provided safely and effectively in other settings. This capacity must exist in addition to capacity reserved for forensic patients. In turn, this will allow the new intensive rehabilitation and community rehabilitation models of care to operate in the least restrictive way possible. The details of the recommended expansion of civil capacity at Thomas Embling Hospital are outlined in Chapter 23: Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems.

(Royal Commission Report, Volume 1, page 625)

Media Responses

Responses in the media came from two sources - news outlets, and organisations/community stakeholders.

The majority of publications acknowledged the Royal Commission's findings that consumer control is central to reform. On this basis, community treatment orders that restrict consumers' autonomy are a direct contradiction of the Royal Commission's findings.

News Outlets

Title: Victoria's mental health royal commission finds the system in 'crisis mode'.

- https://www.theguardian.com/australia-news/2021/mar/02/victoria-mental-health-royal-commission-finds-system-in-crisis-mode
- Release Date: Tuesday, 2nd March, 2021
- "A scathing royal commission report on Victoria's mental health crisis has found the mental health system is "crisis-driven", not designed to support people living with mental illness or psychological distress, and is **overly reliant on medication** and hospitals to treat people."
- The mental health royal commission report challenges the **outdated mental health system with the overuse of medical treatment**. Suggestions were made to include the community as an integral part of mental health and wellbeing.
- Victorian premier, Daniel Andrews, said "The truth is that suffering just isn't being taken seriously enough". "People are either 'not sick enough' for help, or 'too sick' to treat outside a hospital."
- After extensive talks with mental health experts it was found that mental health and wellbeing have been a low priority for the government at all levels.
- Furthermore, the system is overwhelmed and understaffed to handle the influx of people who seek care and treatment. There is an imbalance in the use of non-medicated and medicated forms of treatment.
- The final report describes how "increasingly, a person must exhibit signs of major distress or crisis before treatment, care and support are provided".
- The premier said that every recommendation would be implemented

Title: 'We are failing': Premier vows to put mental health at centre of biggest social reform in generation.
https://www.theage.com.au/national/victoria/we-are-failing-on-mental-health-premier-pledges-biggest-social-reform-in-generation-20210302-p576xe.html
Release Date: Tuesday, 2nd March, 2021

- “Victoria’s failing mental health system will be fundamentally reformed with a new mental health act”.
- Mental Health consumers **still have their human rights breached through compulsory treatment**, seclusion and restraint.
- Families and carers were left out, stigma and discrimnation were ever present and services were difficult for many people to afford.

Title: Victoria's mental health system 'catastrophically failed to live up to expectations', royal commission finds.
https://www.sbs.com.au/news/victoria-s-mental-health-system-catastrophically-failed-to-live-up-to-expectations-royal-commission-finds
Release Date: Tuesday, 2nd March, 2021

- This focuses on the critical nature of Victoria’s mental health crisis and the recommendations that address shortages of treatment options e.g. creation of a new Mental Health and Wellbeing Act.

Title: Royal commission’s assessment into Victoria’s “broken” mental health system delayed.
https://7news.com.au/politics/law-and-order/mental-health-commission-report-delayed-c-2089963
Release Date: Thursday, 4th March, 2021

- This article reports on effects of COVID-19 in delaying consultations and consequently the findings being released

Title: Victoria's mental health system operates in 'crisis mode', royal commission finds.
https://www.9news.com.au/national/royal-commission-victoria-mental-health-system-overwhelmed-final-report/46538a6f-1642-49a3-831a-873bac476853
Release Date: Tuesday, 2nd March, 2021

- Sites the key recommendations as “establishing between 50 and 60 new adult or older adult local mental health and wellbeing services”.
- **As well as current costs and failures of the mental health system with people ‘People are either 'not sick enough' for help, or 'too sick' to treat outside a hospital.’**
- Focusing on the inadequacy of emergency departments to deal with mental health crises.

Title: Victorian mental health royal commission final report finds system operates in crisis mode
https://www.abc.net.au/news/2021-03-02/victorian-mental-health-royal-commission-final-report/13203938

Release Date: Tuesday, 2nd March, 2021

- This report focuses on emergency departments not being the first point of assistance.
- But also mentions **'making compulsory treatments an option of last resort.'**
- "The report said the system was **"over-reliant" on medication."**
- Majority of the article outlines recommendations that improve access to mental health treatment.

Title: Royal Commission into Victoria's Mental Health Services shows region's failing system

The Standard: local newspaper for south-west Victoria region

https://www.standard.net.au/story/7150098/mental-health-system-failing-regional-and-rural-communities/

- Focuses on the need for support services for young people.
- "there does need to be much, much clearer focus on young people, whether that be in school, dedicated youth mental health services and expansions of programs."
- As well as the need for better services in rural areas.

Title: Victorias Mental Health System needs urgent reform

https://www.theaustralian.com.au/nation/victorias-mental-health-system-needs-urgent-reform-catastrophically-failed/news-story/5ade94d1aee570b50a08ed9dffbe3a92

Release Date: Tuesday, 2nd March, 2021

- Behind a paywall.

Title: Victoria commits to establishing Mental Health and Wellbeing Commission

The Mandarin: News for the Public Sector

https://www.themandarin.com.au/150448-victoria-commits-to-establishing-mental-health-and-wellbeing-commission/

Release Date: Tuesday, 2nd March, 2021

- Focuses on the overall recommendations of the report.
- **Does mention "the views of people with lived experience of mental illness are overlooked" which is not often reported.**

Title: Royal Commission makes 65 recommendations in bid to fix 'broken' Victorian mental health system

https://www.news.com.au/lifestyle/health/mental-health/royal-commission-makes-65-recommendations-in-bid-to-fix-broken-victorian-mental-health-system/news-story/2e91f43fa6811de35978013d8c3facd1

Release Date: Tuesday, 2nd March, 2021

- **'Over-reliance on medication': Mental health services have come to rely on medication as the main, or sometimes only, treatment people can receive. This is due to major system-wide challenges, such as under-resourcing, the report states. 'This has led to an**

imbalance, with a lack of focus on therapeutic interventions and recovery-centred treatment, care and support'.

- But in listing the key recommendations, does not mention 55.

Title: Victoria Mental Health Royal Commission 'shone a light on a failed system'
https://www.skynews.com.au/details/_6236493110001
Release Date: Tuesday, 2nd March, 2021

- Triple zero call would be directed to Ambulances rather than police.
- Mental Health Act

Title: Mental health royal commission final report welcomed in northern Victoria
Shepparton News: Goulburn Valley
https://www.sheppnews.com.au/benalla-news/2021/03/15/3771606/mental-health-royal-commission-final-report-welcomed-in-northern-victoria
Release Date: Monday, 15th March, 2021

- General praise for hte RC Report and the Government's response - '2020-21 Victorian budget includes $868.6 million to focus on priority areas such as acute mental health beds, suicide prevention, indigenous social and emotional wellbeing, and support for the mental health workforce.'

Title: Delivery Mental Health Help When and Where Youth Need It
https://www.thecourier.com.au/story/7174573/delivering-mental-health-help-when-and-where-youth-need-it/
Release Date: Friday, 19th March, 2021

- Focuses on issues faced by young people and people in rural areas
- 'For too long, policy-makers have ignored the additional geographic, transport, and socioeconomic barriers regional communities face.'

Organisations' Media Releases

Mental Health Victoria
Title: Lives will be saved: Mental Health Victoria welcomes Royal Commission's bold vision for the Victorian mental health system.
https://www.mhvic.org.au/images/PDF/media_releases/MHV_Ltd_RC_Media_Release_02.03.21_FINAL.pdf
Release Date: Tuesday, 2nd March, 2021

- ‘The Royal Commission has set a very high bar for Victoria. **Once the reforms have been implemented, the Victorian system will become the national benchmark.** We hope that the other states and territories follow Victoria’s lead,” Mental Health Victoria CEO Angus Clelland said.’

Law Institute Victoria Media

Title: Response to Royal Commission into Victoria’s Mental Health System

https://www.liv.asn.au/Staying-Informed/Media-Releases/Media-Releases/March-2021/Response-to-Royal-Commission-into-Victoria’s-Menta

Release Date: Wednesday, 3rd March, 2021

- ‘The LIV welcomes the Royal Commission’s ambitious reinvention of the mental health system including the **phasing out of seclusion and restraints** and **moving away from a medication-based system** to an integrated service approach.’

Australian Services Union

Title: Royal Commission into Victoria’s Mental Health System

https://www.asuvictas.com.au/royal-commission-into-victorias-mental-health-system/

Release Date: Wednesday, 3rd March, 2021

- Mentions recommendations 3, 57, 58 and addressing the ‘missing middle’ of mental health services.

Croakey: not-for-profit public interest journalism organisation

Title: Victoria’s Mental Health Royal Commission promises to transform “failed system”

https://www.croakey.org/victorias-mental-health-royal-commission-promises-to-transform-failed-system/

Release Date: Tuesday, 2nd March, 2021

- Report ‘describing “catastrophic failings” in the system including **over-reliance on medication**, **compulsory treatment** and acute care…’
- ‘reorienting the system towards **community-based treatment** and away from hospitals and cute care.’
- **‘Shocking breaches of human rights:** Chair Armytage said under-resourcing of Victoria’s mental health system has led to an **over-reliance on medication and too little offered by way of therapeutic and recovery-oriented services**,’
- ‘Mental health consumers also had their **human rights breached through the use of compulsory treatment, seclusion and restraint, and not as last resort,** she said, again quoting a person with lived experience.’

Centre for multicultural youth

Title: Royal Commission into Victoria's Mental Health System Final Report

https://www.cmy.net.au/cmy-news/royal-commission-into-victorias-mental-health-system-final-report/

Release date: Monday, 8th March, 2021

Uniting Vic.Tas: community services and mental health support providers

Title: Response to Royal Commission into Victoria's Mental Health System

https://www.unitingvictas.org.au/response-to-royal-commission-into-victorias-mental-health-system/

Release Date: Tuesday, 2nd March, 2021

Dr Tim Read Greens MP For Brunswick

Title: Royal Commission Into Victoria's Mental Health System

https://www.timread.org.au/royal_commission_into_victoria_s_mental_health_system20210310

Release Date: Wednesday, 10th March, 2021

Parent-Infant Research Institute

Title: PIRI statement on Royal Commission into Victoria's Mental Health System

https://www.piri.org.au/piri-statement-on-royal-commission-into-victorias-mental-health-system/

Release Date: unknown

VicHealth: health promotion foundation

Title: VicHealth welcomes findings and recommendations from Royal Commission into Victoria's Mental Health System Final Report

https://www.vichealth.vic.gov.au/media-and-resources/media-releases/mental-health-royal-commission

Release Date: Thursday, 4th March, 2021

BEING: NSW Mental Health Consumers Organisation

Title: Public Statement: Response to Final Report of the Royal Commission into Victoria's Mental Health System

Being noted recommendations 9,10,13,23,25,28 & 29 from the VRC report, and on making similar changes urgently in NSW:

> While we congratulate the Victorian Government for taking such steps to establish a Royal Commission, we call on the NSW Government to investigate our current system to ensure accountability of services to the people who access them. BEING – Mental Health Consumers CEO, Irene Gallagher, states 'there is a disparity between the perspectives of decision makers such as Governments and people who access mental health services. Our survivor movement has been calling for change yet little is being done to bring about reform. We need action and we need it now'.

Eight of *Being'*s 35 'Key Systemic Problems' this NGO had identified in the VRC Report Executive Summary corresponded to JA's specific concerns, included medication over-use, and the failure of the criminal justice system, but did not refer to CTO's nor the 'forensic'/'corrective patient':

- The system has become imbalanced with an over-reliance on medication – Page 8
- The focus on personal recovery needs to be strengthened – Page 12
- People in the criminal justice system do not get the support they need – Page 16
- The system's foundations need reform – Page 16
- Investment in the system is inadequate – Page 17
- Regulation and oversight is complex and unclear – Page 17
- Dignity is often disregarded and human rights are breached – Page 18
- The value of lived experience work is starting to be recognised, but faces challenges – Page 18

https://being.org.au/public-statement-response-to-final-report-of-the-royal-commission-into-victorias-mental-health-system/

Release Date: Wednesday, 3rd March, 2021

Justice Connect: legal support and services organisation

Title: Housing a welcome focus in Victoria's Mental Health Royal Commission

https://justiceconnect.org.au/housing-a-welcome-focus-in-victorias-mental-health-royal-commission/

Release Date: Wednesday, 3rd March, 2021

Health Services Union National

Title: HSU welcomes findings and recommendations of the Royal Commission into Victoria's Mental Health System

Branches of the HSU around the country represent frontline staff working in mental health. In Victoria, we represent more than 3,000 mental health professionals employed as nurses, allied health professionals, administrative staff and peer support workers.

'The Interim Report of the Royal Commission into Victoria's Mental Health System, released yesterday, clearly echoes the position of our members that a respected, skilled and motivated workforce is essential to the delivery of high-quality mental health services for people living with mental illness.

In particular, we welcome the Commission's interim recommendations to:

-Immediately boost service capacity via an additional 170 youth and adult acute mental health beds.

-Begin addressing the workforce crisis through expanding the number of funded graduate and postgraduate placements for allied health professionals and nurses (this was a key recommendation in the HSU Victoria No. 2

Branch [HACSU] submission and we are pleased the Commission embraced it).

-Recognise the need for significant investment in mental health services by establishing a levy to directly fund mental health services.'

https://hsu.net.au/2019/11/hsu-welcomes-findings-and-recommendations-of-the-royal-commission-into-victorias-mental-health-system/

Release Date: unknown 2019

The Florey Institute of Neuroscience and Mental Health

Title: The Florey welcomes the Royal Commission's interim report into Victoria's mental health system

Responding to the interim report, it stated:

> Professor Petrou said he was pleased the Commission had recommended the development of a Victorian Collaborative Centre for Mental Health and Wellbeing.
>
> 'Research can play a transformative role in preventing, diagnosing and treating mental illnesses. We believe that partnerships and collaborations across all areas of the mental health system is necessary to continue improving outcomes for the individuals affected.'
>
> 'We endorse the view that bringing together people with lived experience, researchers and experts in clinical care would have an enormous impact for the community.'

https://florey.edu.au/about/news-media/the-florey-welcomes-the-royal-commissions-interim-report-into-victorias-men

Release Date: unknown

Mental Health Carers NSW

Title: MHCN Public Statement in Response to the Royal Commission into Victoria's Mental Health System's Final Report

It calls for system transformation including in NSW; supports consumer groups, *Being* in NSW, *Tandem* in Victoria, parallels in VRC with recommendations from the Review of Seclusion Restraint and Observation in NSW ('RSRO') in December 2017 that included working towards the elimination of seclusion & restraint; develop better consumer feedback measures for quality measures/data; and for a new agency, peer workforce.

Also it noted VRC similarities in the 'many of the defects identified, and many of the service reform objectives and outcomes articulated previously in 'Living Well the Strategic Plan for Mental Health in NSW.'

> MHCN supports BEING – Mental Health Consumers NSW, 'BEING', in its call for decision makers in NSW to reflect on recommendations in the final report by the Victorian Mental Health Royal Commission, released earlier this week.

MHCN also supports ‘Tandem’ the mental health carer peak body for Victoria, in its statement ‘The current Royal Commission into Victoria’s Mental Health System is a once-in-a-generation opportunity for us to truly transform mental health support for generations to come.’

Systemic problems that inquiry identified in Victoria are also relevant across Australia, including in NSW. We have an overburdened system that too often effectively denies access to many in need of support and only operates in a crisis mode. But care delayed is care denied. Yet the voices of people with lived experience of mental illness and of their families and carers do not seem to matter enough to provoke change, and nor do the disastrous outcomes that our system too often allows to befall them.

The VRC’s findings of the inadequacy of the system and its failure to live up to community needs or expectations are shocking, but not unexpected. There have been numerous inquiries into the adequacy of the Australian mental health system and other human services in various states and nationally that have made similar findings (see MHCN Human Rights Submission 2019).
Indeed in December 2017 the Review of Seclusion Restraint and Observation in NSW (‘RSRO’) made many similar recommendations. The VRC’s recommendation 9, for inclusion of ‘Safe Spaces’ and ‘crisis respite facilities’ (for pathways to urgent care for people experiencing a mental health crisis, including risk of suicide), seems similar in motive at least to RSRO’s recommendation 15 ‘all emergency departments should have clinical pathways for people presenting with mental health issues that are reflective of their needs. There needs to be a pathway that does not include the use of safe assessment rooms.’
The VRCs recommendation 28 ‘developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress’ mirrors the RSRO’s recommendation 10 ‘the peer workforce should be developed and professionalised…’
There was no precise equivalent in the RSRO report to the VRC’s recommendation 29, for ‘the creation of a new agency led by people with lived experience of mental illness or psychological distress’. Both inquiries recommend working towards the elimination of seclusion and restraint.

and

We note that the RSRO in this state has prompted a lot of work by the Mental Health Commission and the Mental Health Branch, LHDs, services and agencies to address many of the defects identified, and many of the service reform objectives and outcomes articulated previously in “Living Well the Strategic Plan for Mental Health in NSW”. But at a system wide

level it is also unclear exactly how effective this work has been, where it has failed (if anywhere), what. if any obstacles might exist to its success or further improvement and therefore what strategies might be needed to help?
However, MHCN endorses BEING and others in saying that empowering people with lived experience of mental illness and those who care for them over and within mental health services will help a great deal. Short of sophisticated data measures (and even with them), asking consumers and carers about their experience of the support received from services is the key and in some ways the only real measure of those service's value. Our systems must become much more responsive to this. YES and CES are excellent general measures, but specific issues require specific measures to understand, monitor and resolve them.

MHCN also strongly endorses and echoes' Tandem's just demand, that Victorian's and all Australian's have the right to expect a mental health system to be delivered by their state and federal governments that is: Safe, Accessible, Fair and Funded!

It really seems like the very least an enlightened society could be expected to provide for its people when they are at their most vulnerable. In NSW MHCN will continue to build its Mental Health Carers Advocacy Network Register to empower mental health carers and their community to advocate for a system very similar to that which the VRC recommends here as well!

https://www.mentalhealthcarersnsw.org/mhcn-public-statement-in-response-to-the-royal-commission-into-victorias-mental-health-systems-final-report/
Release Date: Tuesday, 9th March, 2021

PricewaterhouseCoopers Consulting (Australia) Pty Ltd
Title: The Royal Commission into Victoria's mental health system Interim Report: PwC commentary: Interim Report summary, key themes and recommendations
https://www.pwc.com.au/health/mental-health-RC-interim-report-comp.pdf
Release Date: March

- Report responding to the Royal Commission.

Australiasian College for Emergency Medicine
Title: ACEM statement - Royal Commission into Victoria's Mental Health System
https://acem.org.au/News/March-2021/ACEM-statement-Royal-Commission-into-Victoria's
Release Date: Wednesday, 3rd March, 2021

Turning Point: Australian national addiction treatment, training and research centre

Title: Statement on the Royal Commission into Victoria's Mental Health System

https://www.turningpoint.org.au/about-us/news/statement-royal-commission-victoria-mental-health-system

Release Date: Tuesday, 2nd March, 2021

PANDA: Perinatal Anxiety and Depression Australia

Title: PANDA statement on Royal Commission into Victoria's Mental Health System

https://www.panda.org.au/news-media/panda-media-statement

Release Date: Tuesday, 2nd March, 2021

Forensicare: Victorian Institute of Forensic Mental Health

Title: Forensicare's response to the Royal Commission into Victoria's Mental Health System

https://www.forensicare.vic.gov.au/forensicares-response-to-the-royal-commission-into-victorias-mental-health-system/

Release Date: Thursday, 4th March, 2021

Beyond Blue: Mental Health and Wellbeing Support Organisation

Title: Beyond Blue welcomes landmark Royal Commission into Victoria's Mental Health System Final Report

https://www.beyondblue.org.au/media/media-releases/media-releases/beyond-blue-welcomes-landmark-royal-commission-into-victoria-s-mental-health-system-final-report

Release Date: Tuesday, 2nd March, 2021

Melbourne City Mission

Title: MCM welcomes ground breaking mental health Royal Commission

https://www.mcm.org.au/news/mcm-welcomes-ground-breaking-mental-health-royal-commission

Release Date: Tuesday, 2nd March, 2021