



## WITNESS STATEMENT OF PROFESSOR NEIL REES

I, Professor Neil Rees, currently retired, say as follows:

### ***Professional Background***

- 1 I have held the previous roles:
  - (a) Director of Clinical Legal Education at the University of New South Wales from 1980 to 1986.
  - (b) Assistant Director of Policy and Research for the Victorian Attorney General's Department from 1986 to 1987.
  - (c) The first President of the Mental Health Review Board (**MHRB**) in Victoria from 1987 to 1991.
  - (d) Chairperson of the Victorian Psychosurgery Review Board from 1987 to 1991.
  - (e) Foundation Dean of the University of Newcastle Law School from 1991 to 2000.
  - (f) Member of the Mental Health Review Tribunal in NSW (**MHRT NSW**) from 1992 to 2005, the NSW Equal Opportunity Tribunal from 1994 to 1998 and the NSW Administrative Decisions Tribunal from 1998 to 2007.
  - (g) Chairperson of the Victorian Law Reform Commission (**the VLRC**) from 2007 to 2012.
  - (h) Foundation Co-Head, Law School, University of the Sunshine Coast from 2013 to 2016.
- 2 I am also one of the co-founders of the Monash Springvale Community Legal Centre.
- 3 I obtained a Bachelor of Laws (with honours) and a Bachelor of Jurisprudence from Monash University in 1973 and I was admitted to practice as a barrister and solicitor of the Supreme Court of Victoria in 1975 and as a solicitor of the Supreme Court of NSW in 1980. I obtained a Master of Laws from Southern Methodist University in Dallas, Texas, USA in 1981.
- 4 I am Emeritus Professor of Law at both the University of Newcastle and the University of the Sunshine Coast. In 2017, I became a Member in the General Division for the Order of Australia (AM) for services to the law.

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

5 I am giving evidence to the Royal Commission in my personal capacity.

## **MENTAL HEALTH LAWS**

### ***The history of mental health laws in Victoria***

6 Some years ago, I published an article titled 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform'<sup>1</sup> in which I described the history of Victorian mental health legislation from 1867 until 2007.

### ***Key learnings from the reform of mental health laws over past few decades***

7 About once in a generation, since the first non-indigenous settlement in Victoria, there has been a commission or inquiry established to analyse the ills of the mental health system. Inevitably, after each Commission report, new legislation was formed and then the process was repeated a generation later when people concluded that the system was not working as well as had been hoped.

8 The New South Wales psychiatrist, Dr John Ellard, made the point that almost every Australian piece of mental health legislation for the past century has been a rewrite of the *English Lunacy Act of 1890*.<sup>2</sup> I agree with this view. While there have been pendulum swings in the precise content of Australian mental health laws, their legal purpose has remained the same. Mental health acts authorise conduct that would otherwise be unlawful: loss of liberty and loss of the right to choose whether to accept medical treatment. Mental health laws authorise the detention of people, either in an institution or in their own home or in some community setting and authorise them to be given medication without their consent, if necessary. These laws also establish administrative machinery to facilitate and review these authorisations, such as the functions and powers given to authorised psychiatrists and mental health review tribunals. In legal terms, the new mental health Acts do not do much more than the earlier Acts. The *Mental Health Act 2014 (Vic)* (**the MHA**), is in legal essence, almost the same as the *Mental Health Act 1986 (Vic)* (**the 1986 Act**).

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<sup>1</sup> (2009) 16 *Psychiatry, Psychology and the Law* 69

<sup>2</sup> J Ellard, 'The Madness of Mental Health Acts' (1990) 24 *Australian and New Zealand Journal of Psychiatry* 167, 174

***The merits and limitations of excluding voluntary treatment from mental health laws***

- 9 This is a long-standing debate. From time to time, mental health legislation in Victoria and other states have dealt with voluntary admission or informal admission (as it was sometimes called in the past). I have always been a supporter of the view that it is sensible to have part of the MHA dealing with voluntary admission, even though it is not necessary for legal purposes.
- 10 It is important to emphasise that voluntary treatment for mental illness is preferable. Inclusion of a voluntary treatment provision in mental health legislation is a useful reminder to both mental health professionals and consumers of their services that voluntary treatment is available and that involuntary treatment is a last resort.
- 11 However, even in the absence of an express voluntary treatment provision, there is nothing preventing a person from presenting at a psychiatric institution seeking voluntary treatment, other than the availability of treatment at that facility. There will never be an effective law which mandates that a person wanting voluntary treatment, must receive that treatment from an institution as this is a resourcing issue.
- 12 The argument against having a law solely focussed on voluntary mental health treatment is that we do not have a statute which authorises hospital admissions or community treatment for other purposes, such as cancer or heart treatment, to give birth to a baby or to remove an appendix. These matters are simply dealt with through the general body of law governing the provision of medical treatment.

***Obligations on the State or mental health services to provide services to minimise the impacts of mental illness, rather than using compulsory treatment after a person experiences a decline in their mental health***

- 13 My view is that there could never be an effective legal obligation imposed on the State to provide services to minimise the impacts of mental illness, rather than using compulsory treatment after a person experiences a decline in their mental health because in our system of government the allocation of public resources is a political decision. I am not aware of a piece of legislation anywhere which attempts or has attempted to place some obligation on the State to provide treatment to people that has worked effectively. It is ultimately a decision for the executive branch of government to decide where resources are devoted towards mental health treatment.
- 14 There are many examples in the mental health field where various bodies have tried, unsuccessfully, to impose obligations on the State to reduce the use of compulsory treatment or to improve the quality of that treatment.

- 15 As an example, there was litigation in the United States in the 1960s and 1970s where various State courts directed that State-run psychiatric institutions should provide particular treatment<sup>3</sup> in order to detain people as involuntary patients. This ultimately resulted in the facilities being closed.
- 16 The same situation occurred in Victoria when I was the President of the MHRB. We were conducting hearings at forensic facility, J Ward at Ararat, where the conditions were inadequate. We conducted the hearings and told the Government that the conditions were below any acceptable standard, and that people should not be kept there as involuntary patients unless further and better facilities were provided. Consequently, the Government closed the institution as it did not wish to put itself in a position where they were legally obligated to provide treatment. Such a legal obligation requires resources and it is an acutely political decision as to where resources should be allocated. In an ideal world, the Government would willingly put itself in a position where it is legally obligated to provide reasonable treatment, however I am not aware of any example where there has been a successful legal mandate of treatment.

### ***Values to guide changes to future mental health laws***

- 17 In Australia, we have clearly moved on from the earlier mental health laws that were essentially based upon 'beneficence' – an old-fashioned notion that we take people who are unwell under our wing and care for them. We are now in an era where 'dignity' is to the fore; that value must continue to guide people who devise mental health laws.
- 18 A matter of real difficulty is that psychiatry has been over sold for the past few hundred years. It has significant limitations. At the baseline, we are dealing with illnesses we do not know the cause of and treatment modalities that do not cure anyone, but simply alleviate symptoms.
- 19 Most people with relatively serious mental illnesses have episodic illnesses. We know that there is a genetic link with serious mental illnesses, but we do not know how a person acquires a particular mental illness. We know that in many instances, medication will ameliorate some of the most disturbing symptoms, but we do not know why that is the case, and we do not have medications that cure the illness.
- 20 Therefore, my view is that we must understand that there is not a 'magic formula' that can be applied to future mental health laws. Keeping human dignity at the forefront and having a real awareness of the limitations of psychiatry is important. We rely too much on

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<sup>3</sup> *Wyatt v Stickney* 325 F Supp 781 (1971); J Petrila, 'Rights-Based Legalism and the Limits of Mental Health Law: the United States of America's Experience' in B McSherry and P Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010)

psychiatrists and we ask too much of them given the current state of medical knowledge. It seems, also, that some psychiatrists tend to oversell what their profession is capable of achieving in the field of mental health treatment and care.

***The key features of best practice approaches to developing or amending legislation***

- 21 It is an incredibly difficult undertaking to develop or amend mental health legislation. We need to move our approaches of developing or amending legislation beyond a 'hunch', which is what has driven past legislative change.
- 22 There was no significant legal change from the 1986 Act to the current MHA. The work for the MHA started in 2008 and it was enacted in 2014. In a six-year period, only very minor changes were made to a hotly contested piece of legislation.
- 23 When developing or amending legislation, we must have appropriate consultation, look to developments in other jurisdictions, and ensure that our legislation is accessible.

*Consultation*

- 24 Mental health legislation is one of the areas where it is helpful to float ideas, let people respond to them, and then try to come up with something that is both broadly acceptable and workable. When I was at the VLRC, I made significant efforts to get a reference on reforms on the MHA. I believed that the VLRC had appropriate processes for community consultation. However, the Department of Health (**DoH**) (now the Department of Health and Human Services) resisted this approach as they wanted to maintain control of the legislation. The DoH were fearful of exposing the 1986 Act to any more open consultation and input into the design of new laws. I believe that responsibility for mental health legislation needs to be taken out of the hands of the DoH in order for it to evolve beyond constant tinkering with laws which have been with us for more than a century.

*Examples from other jurisdictions*

- 25 In a broader world sense, we should be constantly looking at other jurisdictions that are more advanced than Victoria in their approach to mental health laws. We should assess the strengths and weaknesses of their legislation before trying to incorporate successful developments into Victorian law. For example, parts of Canada, such as the provinces of Alberta and Saskatchewan, have been leaders in the development of co and supported decision-making laws. There has also been debate in the United Kingdom for the last ten years on best practice approaches of amending or developing legislation.

*Accessibility of legislation*

- 26 There needs to be improvements in drafting legislation in Victoria – this is a problem that has existed for the last 25 years. The MHA, as currently drafted, requires much improvement. It is an extremely difficult piece of legislation to read for anyone who is not a lawyer specialising in mental health law. It is not difficult to draft reasonably well so that legislation can be accessible to most people.
- 27 I suspect that the current MHA is extremely difficult for clinicians to use. For example, a key issue for me has been the interface between guardianship laws and mental health laws. I am a devotee of what is called the ‘fusion proposal’<sup>4</sup>. That is, it should be permissible to use guardianship laws as a means of substituted decision making for a person receiving mental health care without their consent.
- 28 When I looked at the MHA to see how it dealt with the intersection between guardianship laws and involuntary treatment under mental health legislation - after many minutes of searching, I found an obscure provision in section 71 of the MHA which gives the authorised psychiatrist’s powers primacy over any other powers. It struck me that if someone like me, who has spent large parts of his adult life dealing with mental health legislation, took some time to find the relevant provision, how long will it take a clinician or a person who has an enduring power of attorney for a person who is receiving involuntary mental health treatment to try and understand it?
- 29 The MHA needs to be far more accessible for people. In drafting legislation, you need to separate the substantive provisions from the procedural provisions or otherwise put all the procedural provisions in a schedule. Some states do this better than others. The Queensland *Mental Health Act 2016* is a model of clarity in comparison to the MHA. Victorian legislation drowns in procedural provisions before reaching the nub of what a particular provision is about.
- 30 However, it should be emphasised that while the content of the legislation - the contemporary importance of highlighting the value of dignity and of having appropriate checks and balances on those given extraordinary powers - is absolutely vital, ultimately, the legislation, however well drafted, cannot itself improve the quality of care and treatment of those people with mental health challenges. Good legislation can protect their dignity interests, however, and attempt to ensure that people who are given very extensive powers, do not abuse those powers and exercise them fairly.

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<sup>4</sup> Rees, N, “*The Fusion Proposal: a next step?*” in B McSherry and P Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010)

***Levers used by policy and law makers that ensure legislative changes take into account the potential impact on people living with mental illness***

- 31 Policy levers that ensure that legislative changes consider the potential impact on people living with mental illness are already in place.
- 32 Creating new legislation or amending existing legislation is, in formal terms, a two-step process for the government of the day. First, an approval in principle submission is made to Cabinet where the particular Minister and department with responsibility for the legislation outline in broad terms what they are seeking to do to change or enact new legislation. Secondly, you have a Bill at Cabinet where the Cabinet ministers receive copies of a draft Bill which seeks to implement the proposed changes. Relevant departmental officials and Ministerial advisors have access to these documents. During that process, policy and law makers would have been acutely aware of the fact that making bail law stricter, as an example, would probably have an impact on people with a mental illness. Therefore, there is not an absence of levers in place that should prevent governments from being aware of the possibility that proposed new laws might have a negative impact upon people living with mental illness.

***COMPULSORY TREATMENT***

***The difference between the approach to compulsory treatment in mental healthcare to other areas of healthcare where greater agency is provided to clinicians and individuals***

- 33 Other than in mental health care, we all have complete agency as to whether we have a particular medical treatment or not. The only other way that another person can make the decision for us is if there is a guardian, enduring attorney or under the default provisions in the *Guardianship and Administration Act 2019*. There has been debate now for 30 years about whether one should be able to use guardianship laws to authorise involuntary mental health treatment in some circumstances.
- 34 At first, I was strongly opposed to the use of guardianship laws as a means of providing involuntary mental health treatment because I felt that decisions of this nature were best made by someone at 'arm's length' from the person receiving the treatment. However, over time, I have come to the view that it is vital, in the longer term, that we allow people to appoint somebody else to make all treatment decisions for them in most circumstances. For example, if I ever needed psychiatric treatment and I was not in a position to provide consent to it myself, I would much prefer that my wife made that decision than another person who I had never met before in my life. It is astounding that in the current system, we do not allow people to appoint others close to them to make these decisions for them when they are incapable of doing so themselves.

- 35 However, there must also be an override power. There will always be instances where there is conflict between the family members of a person with mental health challenges and the person requiring treatment which might seriously jeopardise the health of that person. Therefore, there must be an override power in certain very narrowly defined circumstances. I suggest that the override power be given to the authorised psychiatrist following approval by the MHRT. In emergencies the authorised psychiatrist could exercise the power alone if he/she immediately seeks approval from the tribunal.
- 36 This was recommended by the VLRC in 2012 in the '*Guardianship: Final Report*'. The response of the DoH was not positive.

***The extent to which mental health laws can assist to influence the use of compulsory treatment***

- 37 The raison d'être for existing mental health laws is to permit compulsory treatment and detention in some circumstances. Without these laws, people would be breaking the law when providing involuntary treatment because these actions would constitute assault and false imprisonment if the person was detained against their wishes.
- 38 Previously, there was a strong view that the only way to receive a reasonable level of mental health treatment in the community was to be on a community treatment order, rather than just a voluntary patient, because it was so difficult to access public services without a compulsory treatment order. Of course, if you had money or private health insurance, you could receive treatment from private practitioners. But, if you did not have money or private health insurance, the only way to receive a reasonable level of treatment outside hospital was on a community treatment order. I'm not sure if this is still the case but it certainly has been one of the reasons why people have remained on community treatment orders for so long.

***Reducing the rates of compulsory treatment use***

- 39 The ways to reduce rates of compulsory treatment, other than legislative change, is to find cures for mental illnesses and more effective treatment modalities.
- 40 I sat on mental health review tribunals for nearly 20 years in Victoria and New South Wales and my view is that compulsory hospital treatment is not overused. In many instances, compulsory hospital treatment is rationed because there are not enough beds available for everyone who would benefit from admission to hospital. Until treatment improves, there will always be many people who will require involuntary treatment due to incapacity.
- 41 There will be some circumstances where people need treatment and if medical staff had more time and skills, some people could be convinced to sign up for treatment voluntarily.



This is one area where there might be an overuse of involuntary treatment which could be avoided. However, other than this situation, there is not an overuse of compulsory treatment in my opinion.

- 42 Until there are better treatment modalities, there will always be a need for involuntary treatment due to incapacity. For most people with serious mental illness, the illness is episodic and medication will simply alleviate the more distressing symptoms, rather than curing the illness. Many people, understandably, do not like the side effects of some medication, so when they been without an episode for a period, they reduce their medication and the need for involuntary treatment sometimes resurfaces.
- 43 Therefore, until there are cures for mental illnesses and more effective treatment modalities, changes to policy, data collection and dissemination will have limited effect in reducing the rates of compulsory treatment.

#### ***The current threshold for compulsory treatment for civil containment***

- 44 It is appropriate that more than an untreated mental illness is needed to justify state interference by way of civil commitment. Usually, model mental health legislation requires some evidence of 'danger to self or others' as well as the appearance of mental illness before a person can be involuntarily treated and detained. The precise wording of any legislation is, in my opinion, largely irrelevant. It is instructive to consider American empirical research<sup>5</sup>, which analysed the different wording between the mental health legislation in various states, including who was rendered eligible and ineligible for compulsory treatment. The research ultimately found that the wording of the legislation did not make any difference to the rates of compulsory treatment between the various states.
- 45 I spent five years on the MHRB and 13 years on the MHRT NSW. The wording of the NSW legislation is much stricter than it is in Victoria. My on-the-ground experience after 18 years is that the wording of the legislation made no difference to the rates of people who ended up being made involuntary patients.
- 46 However, the symbolism of the involuntary commitment criteria has value because it represents a clear statement by the government that mental illness alone does not justify the use of compulsory treatment. In addition to the appearance of mental illness there must be a finding that you are either a danger to yourself or to others, before the state can intervene, restrict your movement and compel you to receive treatment. For that reason, I would not interfere with the current criteria of the MHA.

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<sup>5</sup> P Appelbaum, *Almost a revolution: Mental health law and the limits of change* (OUP, New York, 1994)

## **INDEPENDENT OVERSIGHT**

### ***The history of the establishment of the Mental Health Review Board***

- 47 The establishment of the MHRB took a long time and it was a well-meaning reform. It was the first time that there was any proper external review of decisions to both detain people as involuntary patients and give them involuntary treatment. It is extraordinary that in Victoria, external review of these decisions did not exist before the 1980s. Prior to that time, the legislation had a statutory *habeas corpus* provision which gave a person who had been made an involuntary patient the right to go to the Supreme Court to review that decision. This provision was very rarely used. There was no widespread availability of legal aid and by the time any such application was listed for a hearing in the Supreme Court, that person would have most likely been discharged from the hospital.
- 48 Deinstitutionalisation started before that 1986 Act came into force.<sup>6</sup> This was due to several reasons. Firstly, there were some in the Cain government and the Labour Party who wanted to deinstitutionalise as a human right. They felt that large psychiatric hospitals were relics which were no longer needed because many people with serious mental illness could be treated in the community. Secondly, the large standalone institutions were incredibly expensive to run and many of them were effectively controlled by the relevant unions. As a result, some senior bureaucrats and ministers felt powerless to control these large institutions or to modernise them. Thirdly, some of the institutions were sitting on extraordinarily valuable land. For example, much of the land near La Trobe University's Bundoora campus, which is now largely housing, used to be the site of four psychiatric hospitals (Larundel, Mont Park, Plenty and Bundoora Repatriation Hospital).
- 49 Therefore, there were many reasons for governments to try to reduce the number of people in psychiatric institutions and close them down. It started with good intentions; however, the problem was that no one was responsible for overseeing the implementation of the deinstitutionalisation. This lack in oversight of implementation led to some extremely unfortunate circumstances. For example, when some of the institutions were closing, I distinctly remember seeing patients in hospitals who were in the process of being discharged into the community. A few days later, after the hospitals had closed, the same people were sleeping on benches in the Bourke Street Mall, as they were simply given little more than train tickets to Melbourne upon discharge.
- 50 As mentioned, the process of deinstitutionalisation started before the 1986 Act, and also before the MHRB came into existence. Legislation was not needed to deinstitutionalise. These were executive and administrative actions. The process occurred throughout the country. While people were discharged from various institutions, many were not provided

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<sup>6</sup> As discussed in 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform' (2009) 16 *Psychiatry, Psychology and the Law* 69

with anywhere to live. Thus, a consequence of deinstitutionalisation was that many people who had been patients in psychiatric hospitals ended up living on the streets or in boarding houses. This led to *the National Inquiry into the Human Rights of People with Mental Illness* by the Australia Human Rights Commission (the Burdekin Inquiry) and National Mental Health Plans.

- 51 Following deinstitutionalisation, mainstreaming started. This involved closing psychiatric hospitals and establishing psychiatric wards at major general hospitals. In my opinion, this change was beneficial for psychiatrists, but not for the patients. The standalone psychiatric hospitals were generally much more comfortable for people to live in than one of the psychiatric wards in general hospitals.

*A Board rather than a Tribunal*

- 52 The reason why the MHRB was originally set up as a 'Board' rather than a 'Tribunal,' was because 'Board' was a term in vogue in Victoria for many years. At the time of the MHRB's establishment, every new tribunal was called a 'board.' The other 'boards' created in the 1980s included a separate body dealing with guardianship called the Guardianship Board and a separate body dealing with anti-discrimination cases called the Equal Opportunity Board. Bodies called Wages Boards had been responsible for setting terms and conditions of employment for some workers since the 1890s. My understanding is that 'board' was seen as a softer term than 'tribunal,' and that its use would encourage board members to be as non-legalistic as possible.
- 53 Being as non-legalistic as possible was certainly my aim when setting up the MHRB. We sought to make hearings as accessible and informal as possible so that people could participate and emerge from a hearing without being harmed by the process. The most difficult legislative requirement to comply with when seeking to be non-legalistic was the very important obligation to comply with the rules of procedural fairness or natural justice. This non-legalistic, 'do no harm' approach sits at the core of what is now known as therapeutic jurisprudence.

***The Mental Health Review Board not being incorporated into the jurisdiction of the Victorian Civil and Administrative Tribunal***

- 54 I believe that the decision not to incorporate the MHRB into the Victorian Civil and Administrative Tribunal (VCAT) was the outcome of a 'turf war' between the departments of Health and Justice. VCAT was a Justice creation and therefore, all the Justice tribunals fell into VCAT in the same way as in NSW, the NSW Civil and Administrative Tribunal was the Attorney-General's creation which included all of the tribunals which fell within that portfolio. The DoH fought extremely hard to ensure that the MHRB did not form part

of VCAT because I believe they wanted to have the power to appoint members of the MHRB.

- 55 Ultimately, it has been for the better that the MHRB was not included in the VCAT model. VCAT delivers what I call, 'no frills justice'. The MHRB probably has a few more frills which enhance the dignity of those people who come before the tribunal. Further, the expertise that people build on mental health review tribunals is incredibly important in terms of knowing things such things as what relevant facilities are available in the community. It is difficult for people without a background in psychiatry to understand the language and treatment modalities used in mental health care. In a standalone tribunal people tend to build up appropriate expertise faster. My view is that there are no disadvantages, and distinct advantages, of having a separate Tribunal to make decisions on the use of compulsory treatment.

***The principles, characteristics and components of contemporary, best practice regulatory approaches to safety and quality in mental health service delivery***

- 56 Firstly, more research is required into the effectiveness of particular service delivery modalities. For many years, I was a strong proponent of establishing a National Mental Health Commission. I believe that we need an independent, expert body which can evaluate the effectiveness of treatment modalities, draw attention to innovative modalities used in other parts of the world and provide governments and professional bodies with expert suggestions concerning new treatment modalities which might prove to be effective. As I have now been retired for a few years I am not in a position to comment on whether the National Mental Health Commission is doing any of these things, successfully or otherwise.
- 57 Because we are dealing with conditions for which we do not know the cause and which do not have cures we need to constantly develop new service delivery modalities on a small-scale level with regular testing so that we develop evidence of best practice.
- 58 Secondly, we need to rethink the way we design mental health treatment systems. I believe we have tended to appoint treatment specialists to design entire systems thinking that if they are good at treating people with particular mental health problems then they are best qualified to design the entire system. This is not always the case. I believe we need to train people to be members of a group of specialist system designers. Those system designers could be people from a range of occupations and backgrounds.
- 59 Governments need to work more with the Royal Australian and New Zealand College of Psychiatrists, medical schools and the National Mental Health Commission by constantly consulting to draw upon world's best practice. Much of this work can be done inexpensively and remotely.

## **SAFEGUARDS**

### ***Advance Directives in the Mental Health Act 2014***

- 60 A significant problem with the use of advanced directives in mental health care is that circumstances can change over time. For example, a 35-year-old might say, 'my advanced directive is that I never want Electroconvulsive Therapy (ECT) in my life so do not give it to me.' This is an understandable position for someone aged 35 who might not have experienced crippling depression which causes them to refuse food and drink. However, there may come a time when ECT could be beneficial for that person. Over many years, I have seen that ECT works well in a limited number of cases and has been an appropriate response to keep people alive.
- 61 My view is that you should be able to appoint an enduring power of attorney - a person who can make personal, lifestyle and financial decisions for you. This should include decisions about mental health treatment and care. Once you appoint that person, you can give them advance directives as to how you want them to exercise any power and that person should be obliged to honour your request other than in exceptional circumstances, such as to save your life. Such an override power should only be used with the permission of the Tribunal.

## **FAMILY AND CARER INVOLVEMENT**

### ***Legislative levers to improve family and carer involvement in treatment decisions of their loved ones***

- 62 My view is that you cannot use any legislative levers to improve the involvement of family and carers in treatment decisions. One of the differences between the MHA and the 1986 Acts is the provision in the MHA for a nominated person. However, it was always possible under the 1986 Act for one of your family members or friends to be kept informed and involved in discussions with clinical staff about treatment. Therefore, the inclusion of nominated persons was not really a significant legal change but it was probably important in symbolic terms.
- 63 The difficulty with family and carer involvement is that you must make a case by case decision. In some instances, there will be such conflict between the person receiving the treatment and the close family members that the best thing is to keep them apart for a while. In my experience, this is particularly the case with marriages of long duration that have not been particularly successful. Another situation is a young person with alcohol/drug and mental health issue and parents who desperately want to get involved, but the young person does not wish for them to be involved.

- 64 There will be instances where it will be greatly beneficial that a family member is very involved, and other times where it will be incredibly destructive if the family member is involved. Therefore, clinicians must be able to make decisions on a case by case basis.
- 65 When looking at matters on a case by case basis, we must start from the dignity position. The first question should be, 'does the person getting the treatment want family or carer involvement?'
- 66 The second question is, 'are there any good reasons to move away from what that person wants?' In order to move away from what that person wants, you must be convinced that any decision will not be disadvantageous to that person. For example, if a young person does not want their parents to be involved, but a relapse is likely, the parents may need some information. Clinical guidelines need to be developed on family and carer involvement, not only by psychiatrists, but by social workers as well. My experience has been that often clinicians do not have sufficient time to make balanced decisions about family and carer involvements. Often, social workers who are more highly trained about interactions between various people than medical clinicians, are best placed to undertake this balancing exercise. Whenever possible, a clinical team approach is highly desirable.

## **RESTRICTIVE PRACTICES**

### ***Factors that contribute to the use of restrictive practices***

- 67 The factors that contribute to the use of restrictive practices are patient behaviour and work loads of staff. While physical restraint and seclusion are highly undesirable, without them the only other option often becomes higher dosages of medication. This is particularly so in circumstances where there is a patient with volatile behaviour who is disturbing others in a large ward staffed by only a few nurses. Restraint and seclusion should be permitted, but these restrictive practices must be closely monitored, and clinicians discouraged from over-medicating.
- 68 There have been interesting examples in other countries where complex systems have been devised in an attempt to monitor and minimise the use of restraint in institutional care. This includes the Deprivation of Liberty Safeguards (**DoLS**) made under the *Mental Capacity Act 2005* (UK), that were introduced in April 2009 to address the so-called 'Bournewood gap'.<sup>7</sup> These rules were designed to safeguard against unnecessary restrictions upon the liberty of people in institutions who did not have the capacity to consent to any such restrictions. However, after more than a decade of experience, it is

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<sup>7</sup> *R v Bournewood Community and Mental Health Trust ex parte L (Secretary for Health & Ors intervening)* [1998] 3 All ER 289

widely accepted in the UK that the DoLS have not been successful because they are extraordinarily complex and, therefore, very costly to apply.

***Factors that contribute to the use of restraint and seclusion***

- 69 In my experience, seclusion is generally used as a last resort for people who are in an acutely psychotic state and when reasonable amounts of medication are not assisting them to calm down. It can be used as a measure for their own safety and to protect other patients and staff.
- 70 Sometimes, restraint is used for elderly people who otherwise may fall out of beds or chairs if not constantly monitored. In these circumstances, the use of restraint and seclusion can be an act of kindness to stop people doing themselves great harm.

***Legislation prohibiting the use of restrictive practices in all mental health services***

- 71 I believe that legislation should not prohibit the use of restrictive practices in all mental health services because, as I have explained in paragraphs 69 to 70, it is sometimes necessary to use these practices for the benefit of the person concerned and for others who might be harmed by their behaviour. If people cannot be secluded or restrained in exceptional circumstances we will simply find that they are given increased dosages of anti-psychotic medication in order to control that behaviour.

***Looking to the future***

- 72 Many people have been in the position of this Royal Commission in the past. This is the eighth or ninth commission of inquiry into the state of mental health care in Victoria since the middle of the 19<sup>th</sup> century. This process tends to happen once in a generation and I suspect each commission has undertaken its task with the best will in the world.
- 73 Looking at the history of these commissions, perhaps the most significant reformer of mental health services in Victoria was Dr Eric Cunningham Dax, a British psychiatrist who came to Victoria shortly after World War II. Dax wrote a famous book called 'From Asylum to Community' in 1952. Way back in 1952, Dax argued that we should be releasing people from institutions and providing treatment and care in the community. It clearly took a long time for Dax's theories to be put into practice. Dax was the founding Chairman of the Mental Hygiene Authority of Victoria and he was able to get the Victorian government to increase expenditure on mental health care by 400 per cent. However, despite this extraordinary injection of money into this far sighted idea of moving people from asylum to the community - we now have a Royal Commission in 2020 looking at the system that Dax proposed and started nearly 70 years ago.

- 74 I believe that the Royal Commission needs to be mindful of the fact that many people have been down this path before. There is nowhere in the world that I am aware of which clearly has the best practice in relation to the provision of public mental health service. We should ask - why that is so? Is it because we simply don't know enough about the causes of mental illness and we don't yet have treatment regimes which will eradicate the illness?
- 75 We should not overpromise what can be done because of our inadequate knowledge. We do need to encourage much more research into the most effective delivery of mental health services, not just the efficacy of particular types of treatment. When the 1986 Act came into force, there were well-meaning people who were overseeing the system. However, no-one in a leadership position had any real experience in the design and implementation of mental health services. I am delighted that the Royal Commission is putting emphasis on having an implementation body when trying to bring about far reaching reforms.

sign here ►

A handwritten signature in black ink that reads "Neil Rees". The signature is written in a cursive style with a horizontal line underneath the name.

print name Professor Neil Rees

Date 15 June 2020