

Melbourne Social Equity Institute



Submission to the Royal Commission into Victoria's Mental Health System

July 2019

The Melbourne Social Equity Institute (MSEI) supports interdisciplinary research on social equity issues across the full spectrum of social life including health, law, education, housing, work and transport. We bring together researchers from across the University of Melbourne to identify unjust or unfair practices that lead to social inequity and work towards finding ways to ameliorate disadvantage. We facilitate researchers working with government and community organisations and help with the dissemination and translation of research for public benefit. A strong component of our work concerns mental health and society.

This submission was prepared by Dr Yvette Maker and Dr Piers Gooding. For enquiries, please contact Yvette Maker [REDACTED].

The MSEI welcomes the opportunity to make this submission to the Royal Commission into Victoria's Mental Health System. This submission draws on research conducted at the MSEI and is focused on the **quality and safety of existing and future mental health services** in Victoria, especially those services that involve coercive practices or involuntary treatment.

We agree that improving access to support for people in mental health crisis in Victoria is hugely important. However, we echo the caution issued by the United Nations Special Rapporteur on the Right to Health, Dainius Pūras, that '[t]he scaling-up of care must not involve the scaling-up of inappropriate care'.¹ Services and support will only be appropriate if they are consistent with human rights obligations.

1. Adopt a human rights approach to mental health services and support

Recommendation 1: Ensure all the Royal Commission's recommendations are informed by international human rights law and global trends, especially in regard to the avoidance of coercion.

In 2016, the United Nations Human Rights Committee recognised 'the need to protect, promote and respect all human rights in the global response to mental health-related issues' and 'stress[ed]

¹ Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 35th sess, UN Doc A/HRC/35/21 (28 March 2017) 13.

that mental health and community services should integrate a human rights perspective so as to avoid any harm to persons using them.’²

The United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) provides the most detailed guidance on the requirements of a human rights approach to mental health. Australia is a signatory to the CRPD, and the Victorian government has played a leading role in bringing attention to the application of the CRPD in mental health services. Relevant parts of the CRPD include article 12 (equal recognition before the law), article 15 (the right to be free from cruel, inhuman or degrading treatment or punishment), article 17 (the right to respect for physical and mental integrity on an equal basis with others) and article 25 (the right to enjoy the highest attainable standard of health without discrimination on the basis of disability).

The widespread use of coercion in the provision of mental health services raises particularly potent human rights concerns. The United Nations Committee on the Rights of Persons with Disabilities, which is responsible for monitoring the CRPD’s implementation, has explicitly criticised Australia’s use of ‘unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints...in various environments, including schools, mental health facilities and hospitals’.³ Elsewhere, the Committee has characterised ‘the use of forced treatment, seclusion and various methods of restraints’ as ‘not consistent with the prohibition of torture and other cruel, inhuman or degrading treatment or punishment’.⁴

There is now ample evidence that the use of coercive practices is harmful to consumers and staff. A 2014 MSEI report prepared for the National Mental Health Commission summarised this evidence in relation to the use of seclusion and restraint, pointing to negative consequences including pain, preventable injury, an aversion to help-seeking, a sense of injustice if complaint or monitoring mechanisms are inadequate, and even death.⁵ People subject to restraint have also reported that they perceive the use of restraint as a form of punishment rather than a necessary act.⁶ Negative impacts on staff and the workplace have also been recorded, in terms of trauma and damage to morale and therapeutic relationships.⁷

² United Nations Human Rights Committee, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development*, 36th session, UN Doc A/HRC/36/L.25 (26 September 2017) 2 <<https://undocs.org/A/HRC/36/L.25>>.

³ Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Periodic Report of Australia*, 10th sess, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [35]-[36].

⁴ Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities*, 14th sess (September 2015) [12].

⁵ Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (University of Melbourne, 2014) 16-17 <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>.

⁶ See Caroline Larue, Alexandre Dumais, Richard Boyer, Marie-Helene Goulet, Jean-Pierre Bonin and Nathalie Baba, ‘The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients’ (2013) 34(5) *Issues in Mental Health Nursing* 317-324; Tom Mason, ‘Seclusion as a Cultural Practice in a Special Hospital’ (1993) 1(3) *Educational Action Research* 411-423.

⁷ For example Gwen Bonner et al, ‘Trauma for All: A Pilot Study of the Subjective Experience of Physical Restraint for Mental Health Inpatients and Staff in the UK’ (2002) 9(4) *Journal of Psychiatric and Mental Health Nursing* 465-73; Stuart Bigwood and Marie Crowe, ‘“It’s Part of the Job, but it Spoils the Job”: A Phenomenological Study of Physical Restraint’ (2008) 17(3) *International Journal of Mental Health Nursing* 215-22; Surabhi Kumble and Bernadette McSherry, ‘Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective’ (2010) 17(4) *Psychiatry, Psychology and Law* 551-561.

Clearly, an alternative approach to the design and delivery of mental health services in hospitals and community settings is necessary. Studies published by MSEI researchers could support the design and implementation of a mental health system that prioritises alternatives to coercion.⁸

2. Implement alternatives to coercion

Recommendation 2: Develop and implement a policy charter that collates and implements leading global practices aimed at reducing and preventing coercive practices.

Recommendation 3: In consultation with mental health consumers and their representative organisations, amend the *Mental Health Act 2014* to:

- a) clarify the obligation on services to implement alternatives to coercion;
- b) implement clear monitoring and reporting obligations on the use of all forms of coercion;
- c) provide sufficient resources and training to implement alternatives to coercion in a manner that ensures the safety of all parties.

Recommendation 4: Clearly define chemical restraint and explicitly prohibit its use.

There is evidence that mental health services in many high-income countries are moving away from the compulsory detention and treatment of people with mental health conditions, as well as the use of seclusion, physical force, using belts or straps to restrict movement, or pharmacological interventions to control behaviour. MSEI researchers, commissioned by the United Nations Office at Geneva, recently published a review of the growing body of empirical studies into hospital and community-based efforts to find alternatives to coercive practices in mental health services.⁹ The review demonstrated that a broad suite of practices, policies and interventions exist and can be implemented by governments. A policy charter or framework could collate these findings, outlining the broad package of alternatives that have been introduced and tested elsewhere, or that warrant further investigation. To provide brief examples:

- Victoria could evaluate the impact of ‘open door policies’, as has occurred in Germany on a mass-scale, with reportedly positive results.¹⁰
- Victoria could continue and expand its support for the *Safewards* program, and other hospital-based initiatives aimed at reducing seclusion, restraint and other coercive practices, including employing experts who can influence organisational culture away from coercive practices (e.g. organisational psychologists).
- Victoria could create a legislative requirement for the state government to report annually on developments aimed at reducing and preventing coercive mental health practices, similar to a

⁸ Bernadette McSherry and Ian Freckelton (eds), *Coercive Care: Rights, Law and Policy* (Routledge, 2014); Piers Gooding, *A New Era for Mental Health Law and Policy: Supported Decision-Making and the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press, 2017).

⁹ Piers Gooding, Bernadette McSherry, Cath Roper and Flick Grey, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (University of Melbourne, 2018) <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf>.

¹⁰ Ibid 53-57.

law adopted by the state of Vermont in the United States. In Vermont, the responsible department is obliged under state law to report annually ‘regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available’. A similar reporting obligation could relate to the implementation of the recommended policy charter.¹¹

More detail on these and other practices is available in the report.

Another MSEI project is currently examining options for improving regulation in regard to one class of coercive practice, namely, the use of restraint to control behaviour. There is widespread support for the notion that restraint is over-used and under-regulated in Australia, evidenced by, for example, the National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services issued in 2016 by the Safety and Quality Partnership Standing Committee of the Australian Health Ministers’ Advisory Council.¹²

The goal of the MSEI research is to develop model laws and guidelines to support the reduction, with a view to elimination, of the use of restraint across the country. The study has highlighted several shortcomings of existing regulation in Victoria. At present, the *Mental Health Act 2014* (Vic) (‘the Act’) contemplates and permits the use of ‘bodily restraint’ – which includes both physical and mechanical restraint – where it is ‘necessary’ to either ‘prevent imminent and serious harm to the person or to another person’ or ‘to administer treatment or medical treatment to the person’.¹³ Policy documents state that chemical restraint ‘has no defined place in the Act or in practice’ in Victoria,¹⁴ although advocates and researchers have expressed serious concern about the sedating use of commonly administered medications.¹⁵ Guidelines issued by the Chief Psychiatrist provide more guidance on the use of restraint and emphasise that clinicians have a responsibility to prevent the use of restrictive interventions. These guidelines also note the potential for restraint to traumatise or retraumatise consumers, and suggest that a trauma-informed approach involving engagement with consumers constitutes ‘best practice’.¹⁶

Neither the legislation nor the guidelines provide sufficient guidance on the ‘reasonable and less restrictive options’ that are available to ensure that alternatives to restraint are prioritised and supported. There is also mixed messaging in existing legislation, policies and guidelines, with some emphasising minimisation and others suggesting that avoidance and elimination are appropriate goals. While more detailed information is available in the Chief Psychiatrist’s guideline and other

¹¹ Ibid 38-39.

¹² Restrictive Practice Working Group, *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services* (Australian Health Ministers’ Advisory Council, 2016) <http://www.apha.org.au/wp-content/uploads/2017/05/Att-A-Nat-Principles-mechanical_physical-_restraint-2.pdf>.

¹³ § 13.

¹⁴ Department of Health, *Restrictive Interventions in Designated Mental Health Services: Chief Psychiatrist’s Guideline* (State of Victoria, 2014) 6.

¹⁵ See for example Victorian Mental Illness Awareness Council (VMIAC) *Election Platform By and For Consumers and Survivors of Mental Health Services* (VMIAC, 2018) <https://www.vmiac.org.au/wp-content/uploads/2018/08/VMIAC-Election-Platform_VIC_2018.pdf>; Bernadette McSherry, ‘Chemical Restraint: Behind Locked Doors’, *Pursuit*, 6 June 2017 <<https://pursuit.unimelb.edu.au/articles/chemical-restraint-behind-locked-doors>>.

¹⁶ Department of Health (Vic), above n 14, 4, 6.

policy documents, it is unclear if and how these documents have been incorporated into practice and monitoring at the service level.¹⁷

Clearer legislative obligations on services to identify and implement alternatives, provision for adequate training and resourcing for staff to ensure safe outcomes for all parties, and ongoing reporting and monitoring, are all necessary to ensure that the goals of minimisation and elimination are prioritised and incentivised.¹⁸ Clarity regarding the distinction between ‘chemical restraint’ used for behaviour control and the use of medication for therapeutic purposes, and monitoring and reporting of data on the use of all forms of restraint, would also provide a clearer picture of current practices and further the goals of minimisation and elimination. Any changes must be informed by consultation with people who have been subject to restraint, other mental health consumers, and their representative organisations.

3. Expand options for crisis support

Recommendation 5: Ensure crisis resolution options beyond the hospital setting are available.

Since deinstitutionalisation, mental health policy has been roughly divided into two categories in Victoria: hospital- or community-based care, with services like PARC and CAT serving as a bridge between the two. The hospital is typically presented as a site for acute treatment while the ‘community’ is presented as a site for non-urgent support and prevention. Research undertaken at the MSEI suggests that a more constructive characterisation might be ‘crisis resolution’ on the one hand and ‘general support’ on the other.¹⁹ ‘Crisis resolution could – and should – include hospital-based support, but could also include emergency options like crisis respite houses, intensive home-based support (for example, with practices like Family Group Conferencing and Open Dialogues), residential programmes (such as Housing First initiatives that house homeless people before endeavouring to address issues such as mental illness or drug and alcohol issues), and resources for families, partners, supporters, about assisting someone at home who is in a state of crisis. General support could include the range of non-urgent community-based services that currently exist to help prevent emergencies and assist people to live full lives; for example, by using independent advocacy/case management, housing support, trauma-based counselling and personal assistance. This does not imply that funding for non-hospital crisis support should be drawn from funding for hospitals and other clinical settings, which clearly warrant sufficient funding.

¹⁷ For example, the policy document ‘Providing a Safe Environment for All: Framework for Reducing Restrictive Interventions’ was issued by the Department of Health in 2013 to ‘assist health services to comply with mental health reform objectives and the *Charter of Rights and Responsibilities Act 2006*’. It includes detailed recommendations for reducing the use of restrictive interventions and sets out four ‘capabilities’ that are necessary to support sustained reduction in the use of restrictive practices: see <<https://www2.health.vic.gov.au/about/publications/researchandreports/Providing-a-safe-environment-for-all-Framework-for-reducing-restrictive-interventions>> 2.

¹⁸ See Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report*, above n 5, 168-171; Yvette Maker and Bernadette McSherry, ‘Regulating Restraint Use in Mental Health and Aged Care Settings: Lessons from the Oakden Scandal’ (2019) 44(1) *Alternative Law Journal* 29-36.

¹⁹ Piers Gooding et al, *Alternatives to Coercion in Mental Health Settings: A Literature Review*, above n 9.