

# RESPONSE TO ROYAL COMMISSION

Issues affecting consumers labelled with “serious and persistent mental illness”

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## Questions to VMIAC

The Royal Commission has requested VMIAC to respond to the following questions:

- What types of concerns and hopes do consumers with multiple and enduring support needs raise with VMIAC? How are these similar and different from other members' concerns and hopes?
- What (if anything) do consumers raise with VMIAC as working well currently/what have consumers said they would like to see more of (including in relation to Secure Extended Care Units (SECUs) and Community Care Units (CCUs)?
- How would you describe human rights interfacing with consumers' experiences of service, or lack of service, in the mental health system?
- If consumers with multiple and enduring support needs are in long-term residential care, such as SECUs, or CCUs, what could be done to:
  - ensure the greatest standard of care, as determined by the consumers?
  - best protect consumers' human rights?
- What oversight mechanisms are necessary where a person has multiple and enduring support needs to:
  - ensure the greatest standard of care, as determined by the consumer?
  - best protect their human rights?
- Consumer leadership is something the Commission is considering across its work streams – what role do you see for consumer leadership in the multiagency supports that may be offered when a person has multiple and enduring support needs?

## Our work

1. Since 1981, VMIAC has worked with the people most harmed or disadvantaged by the mental health system. This includes people who engage with multiple agencies and who are labelled as having “severe and persistent mental illness”. While all our operations intersect with this topic, our Individual advocacy, NDIS advocacy and support, and Policy and Communications teams bring particular expertise to these topics.
2. Our **Individual advocacy team** provides advocacy to any individual who identifies as having direct lived experience. This can intersect with the clinical mental health system for voluntary consumers, as well as the community mental health and private systems and providers. Beyond the mental health system, we support consumers who experience disadvantage or marginalization in workplaces, housing agencies and the Department of Housing, child protection and family violence services.
3. Our **NDIS advocacy and support team** provides individual support, information and advice for consumers who are entering or within the NDIS. Our NDIS Information and Support workers help consumers: maximise their NDIS plan to align with their goals, manage services, unpack potentially confusing NDIS language, and self-advocate. Our team also supports consumers who want to appeal a decision by the National Disability Insurance Agency (**NDIA**) by providing information and practical advice, as well as referrals to services for free legal assistance.
4. Our **Policy and Communications Team** engages our members and staff in policy analysis and development on the most pressing issues for our community. This includes specific engagements with our members on the following topics that have emerged during the Royal Commission:
  - a. The Victorian Collaborative Centre for Mental Health and Wellbeing (**Collaborative Centre**)
  - b. Hospital in the home services
  - c. Hospital Outreach Post-Suicidal Engagement (**HOPE**)
  - d. Bed-based “acute” services
  - e. Peer-led services
  - f. Consumer workforce development
  - g. Governance at all levels of the system
  - h. Consumer-led systemic change.
5. In addition, we engage with stakeholders who have a systemic impact (positive and negative) on our membership, such as Independent Mental Health Advocacy, Victoria Legal Aid, Mental Health Legal Centre, the Mental Health Complaints Commissioner, the Office of the Chief Psychiatrist, Safer Care Victoria, and designated community mental health services.
6. Underpinning all our work is our engagement with members. This can be seen most clearly by [The Declaration](#) – a living vision and collective consumer statement of what we want to see from a future mental health system.
7. For further information on our services please contact CEO Maggie Toko ([maggie.toko@vmiac.org.au](mailto:maggie.toko@vmiac.org.au)).

## Considerations for language

8. In providing this advice to the Royal Commission, VMIAC highlights the importance of language in understanding and responding to distress, at relational, organisational, and systemic levels.
9. In 2018, VMIAC published “The Declaration”, which illustrated the results of in-depth engagement with our members on language. We asked members if they “like”, “can live with”, or “dislike” particular terms. Of the results, 85% said that they either liked (71%) or could live with (14%) the term “people with lived experience”. The most disliked term from our results was “mentally ill”, with 63% of respondents saying they disliked the term.
10. While we understand that the term “mental illness” reflects the language set out in the terms of reference, and the challenge this provides Royal Commission staff and Commissioners,<sup>1</sup> we ask that the Commission refrain from using such language wherever possible throughout communications and in the final report. There are several other terms, as were outlined in the questions the Commission has put to VMIAC, that could be used in place of ‘severe and persistent mental illness’, such as “consumers who use multi-agency supports”.

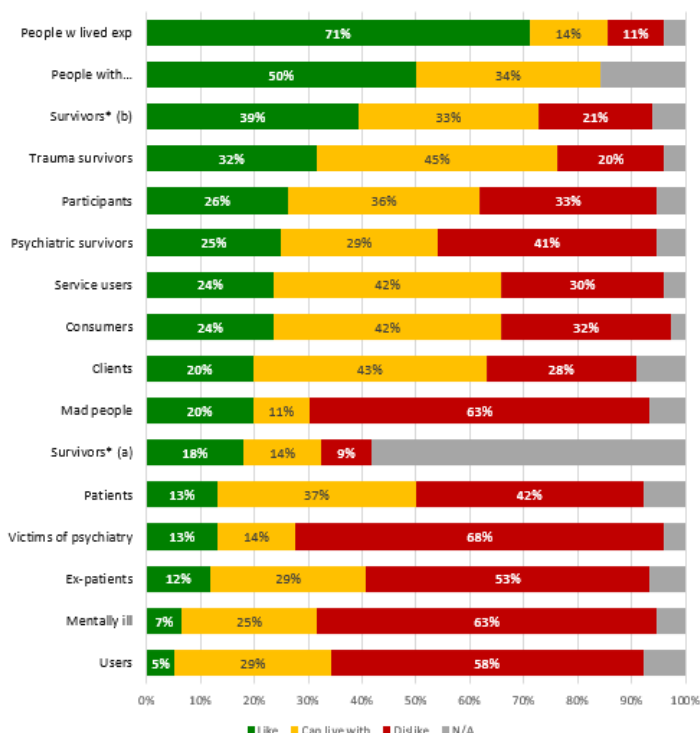


Figure 1 Results from VMIAC Declaration on how people want to be identified – full results available on request.

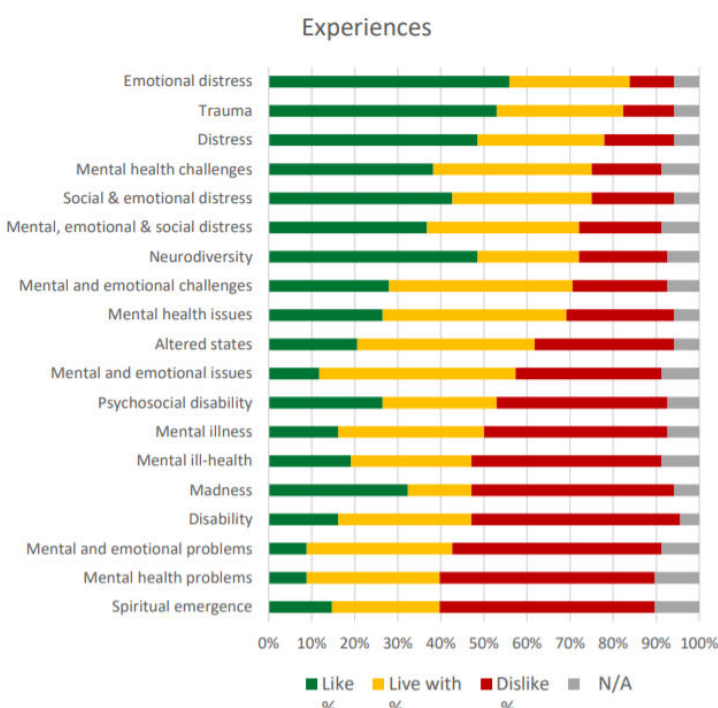


Figure 2 Results from VMIAC Declaration results on how people want their experiences described - full results available on request.

<sup>1</sup> We also appreciate your acknowledgement of this issue in your correspondence with us.

## Response to request for further information



11. Describing the services provided, or makeup of services provided is seen as preferable, and will still ensure that the Commissions' work fits within the bounds of its terms of reference.
12. Consumers did not come up with the terms being used to describe them. For many of these people, certain terms are damaging and hurtful. The term "severe and persistent mental illness" in particular is not recovery-oriented.

## Key concerns & human rights issues

What types of concerns and hopes do consumers with multiple and enduring support needs raise with VMIAC? How are these similar and different from other members' concerns and hopes?

How would you describe human rights interfacing with their experiences of service, or lack of service, in the mental health system?

13. Naturally, our members in this group have diverse views and preferences. The Declaration, however, highlights a vision on what over 200 consumers in Victoria want, including:

- a. How we want others to understand and describe **our experiences**
- b. How we want **society to change**
- c. The concepts, such as **compassion and love**, that we want to underpin a new system
- d. The kinds of **people and values** needed for support
- e. The kinds of **places and services** we want from a future system
- f. The kinds of **actions and support** that we would want from services, politicians, and community
- g. How we want **to access** these supports, and
- h. Our **life outcomes** – in other words, what would be different if our vision were realised.<sup>2</sup>

14. More specific to this topic, consumers have hopes that the mental health system, communities, and government:

- a. Do not rely on **restrictive biomedical models, but rather draw on a diversity of approaches** to understand and respond to consumers' distress. **Eliminate all legal forms of force used against consumers**, including compulsory and coercive treatment, and restrictive practices, while improving the operation of current human rights protections
- b. Better embed the **Charter of Human Rights and Responsibilities Act 2006 (Vic)** in mental health services, regulators, and government departments
- c. Ensure that consumers labelled with serious and persistent mental illness (**SPMI**) enjoy the **same standard of health and healthcare** as the rest of the community
- d. Enable **better access to housing** for people labelled with SPMI (see [paras 94 to 96](#))
- e. Ensure associated services, such as **Child Protection** assist, rather than undermine, consumers' human rights
- f. Ensure that any multi-agency supports are directed and controlled by consumers, based on a **supported decision-making model**

15. Unfortunately, there are several barriers in law, culture and practice that are currently preventing this.

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<sup>2</sup> See further: Tricia Szirom, 'Witness Statement 12 May 2020 to the Royal Commission into Victoria's Mental Health System' (2020) [8-17].

## Biomedical and sanist approaches hold us back

16. Restrictive biomedical accounts of distress fail to serve consumers, particularly those labelled with SPMI, and provide the foundation from which human rights abuses against consumers are perpetrated and justified.
17. A foundation for later abuse starts with conceptions of what is “normal” and what is “abnormal”. Many biomedical accounts of distress carry hidden assumptions of what it means to be “sane”, and police other boundaries such as gender and sexuality. As the receivers of such labels and associated maltreatment, consumers know this experientially. We have been labelled with such “disorders” as “gender dysphoria”,<sup>3</sup> “borderline personality disorder”,<sup>4</sup> as well as previous common diagnoses such as “drapetomania”,<sup>5</sup> “hysteria”,<sup>6</sup> and “ego-dystonic homosexuality”<sup>7</sup> and suffered the consequences of so-called ‘treatment’ for these diagnoses. In Australia, the ‘biomedicalism’ of human experience continues to justify the recasting of Aboriginal spiritual voices as “hallucinations”.<sup>8</sup>
18. Ideas about us affect how clinicians engage with us. Many consumers report that their engagements with clinicians are centred on “managing” their mental illness, rather than the things that matter to them. Their lived experience and strengths often go unacknowledged.
19. Rather than addressing stigma, mental health diagnoses are experienced by many consumers as alienating and ‘othering’. This may be due to negative perceptions and stereotypes associated with certain diagnoses held by the public, which can lead to discrimination and violence towards consumers.<sup>9</sup>
20. Many consumers find traditional biomedical diagnostic and treatment options helpful. These approaches, however, sit alongside other psychosocial and peer support approaches, and should be based on free and informed consent. Moreover, consumers should not be required to “develop insight” or accept that they are “sick” to access these treatments.
21. Medical professionals have long assisted people with pain and distress, without the need to accept organic or biological explanations.<sup>10</sup> Mental health professionals should be no different.

<sup>3</sup> Kristina Olson, Lily Durwood, Madeleine DeMeules and Katie McLaughlin, ‘Mental Health of Transgender Children Who Are Supported in Their Identities’ (2016) *Pediatrics* 137(3), 1-8.

<sup>4</sup> Borderline personality disorder diagnoses are significantly weighted towards female diagnoses, suggesting that symptoms may be the result of gender norms and roles: Pamela Bjorklund, ‘No man’s land: Gender bias and social constructivism in the diagnosis of borderline personality disorder’ (2006) *Issues in Mental Health Nursing* 27(1), 3-32.

<sup>5</sup> The medical condition explaining slaves’ compulsion to escape slave owners: Samidha Tripathi, Erick Messias, John Salomon, Ronald MD, ‘Modern-Day Relics of Psychiatry’ (2019) *The Journal of Nervous and Mental Disease* 207(9), 701-704; Samuel Cartwright, *Report on the diseases and physical peculiarities on the Negro Race* (New-Orleans Medical and Surgical Journal, 1851).

<sup>6</sup> The conclusion that women’s physical symptoms and distress were not real medical conditions, and were instead the result of various unresolved neuroses: Samidha Tripathi, Erick Messias, John Salomon, Ronald MD, ‘Modern-Day Relics of Psychiatry’ (2019) *The Journal of Nervous and Mental Disease* 207(9), 701-704. Many of these elements continue under the “Histrionic Personality Disorder” diagnosis.

<sup>7</sup> Jack Drescher, ‘Out of DSM: Depathologizing homosexuality’ (2015) *Behavioral Sciences*, 5(4), 565-575.

<sup>8</sup> Leoni Cox, ‘Queensland Aborigines, Multiple Realities and the Social Sources of Suffering: Psychiatry and Moral Regions of Being: Part 1’ (2009) *Oceania* 79(2), 97-120. See also: Djirra, *Submission to the Royal Commission into Victoria’s Mental Health System*, (Submission to the Royal Commission into Victoria’s Mental Health System, July 2019) at 41.

<sup>9</sup> Chris Groot, Imogen Rehm, Cal Andrews, Beth Hobern, Rikki Morgan, Hannah Green, Lisa Sweeney, and Michelle Blanchard, *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues* (Anne Deveson Research Centre, SANE Australia, 2020), 154.

<sup>10</sup> Nicholas Rose, ‘Beyond medicalisation’ (2007) *The Lancet* 9562, 700-702.

### Recommendations

Work on stigma and discrimination against consumers labelled with SPMI challenges, rather than reinforce biomedical accounts of distress through:

- Challenging stigmatising and/or discriminatory language used by utilising alternatives (as described above) throughout the Royal Commission's final report
- Ensuring consumers lead and/or co-design all anti-stigma/discrimination efforts to safeguard against the harms associated with restrictive biomedical approaches.

The Royal Commission's broader work provides a balanced approach to mental and emotional distress by:

- Re-framing identified 'problems' and 'solutions' in language that reflects the social model of disability and human rights rather than (solely drawing on) biomedical approaches to distress.
- Ensuring that recommendations challenge the primacy of biomedical approaches to distress by using recovery-oriented and human rights-based language.



## Compulsory treatment, seclusion, and restraint

### Compulsory treatment, seclusion and restraint violates our human rights

22. Our members continue to be subjected to compulsory treatment, even though it:
- Is discriminatory and breaches human rights law<sup>11</sup>
  - Is not evidence-based,<sup>12</sup> and
  - Can be psychologically harmful and traumatic.<sup>13</sup>
23. As outlined by VMIAC elsewhere, compulsory treatment:
- Is inconsistent with article 12 (equal legal capacity), article 25 (informed consent) of the *Convention on the Rights of People with a Disability (CRPD)*
  - May constitute torture and ill-treatment under the *Convention Against Torture and other Cruel, Inhuman or Degrading treatment or Punishment (CATT)*.<sup>14</sup>
24. More of our positions on compulsory treatment can be seen in **VMIAC Policy Position Paper #1: Compulsory treatment (Annexure 1)**.
25. These concerns extend to the use of seclusion and restraint, including chemical restraint. Like compulsory treatment, we have called for the abolition of seclusion and restraint. More of our positions on seclusion and restraint can be seen in **VMIAC Policy Position Paper #3: Seclusion and Restraint (Annexure 3)**.
26. All forms of force should be regarded as a systemic failure to provide engaging and helpful services.<sup>15</sup>

#### Recommendations

- That the Royal Commission interprets and conceptualises all forms of compulsion and forced treatment as evidence of systems failure and breaches of human rights.
- Eliminate compulsory treatment through a comprehensive, funded and coordinated strategy, built on co-production and consumer-leadership and through a staged reduction towards zero.
- Fund alternatives to compulsion and coercion, including improved access to psychological, trauma-based and peer supports within and outside the clinical mental health system.

<sup>11</sup> Christopher Maylea & Asher Hirsch, The right to refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of People with Disabilities' (2017) 42(2) Alternative Law Journal 149-155. This also reflects an unjustifiable restriction on rights under the Charter, that results in a failure for consumers to be treated equally before the law: *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 7(2), 8(4).

<sup>12</sup> Daniel Maughan, Andrew Molodynski, Jorun Rugkasa & Tom Burns, 'A systematic review of the effect of community treatment orders on service use' (2014) 49(4) Social Psychiatry and Psychiatric Epidemiology, 651-663; Lisa Brophy, David Ring, 'The efficacy of involuntary treatment in the community: Consumer and service provider perspectives' (2004) 2(2-3) Social Work in Mental Health 157-174

<sup>13</sup> Edwina Light, Michael Robertson, Phillip Boyce, Terry Carney, Alan Rosen, Michelle Cleary, Glenn Hunt, Nick O'Connor, Christopher Ryan, and Ian Kerridge, 'The lived experience of involuntary community treatment: a qualitative study of mental health consumers and carers' (2014) 22(4) Australasian Psychiatry 345-351; State of Victoria, Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87 (2018-2019), 230.

<sup>14</sup> Penelope Weller, 'OPCAT monitoring and the Convention on the Rights of Persons with Disabilities'. (2019) *Australian Journal of Human Rights*, 25(1), 130-149. *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 8 August 1989) art 1. For commentary from the Special Rapporteur, see; Mendez J.E., Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1 February 2013, A/HRC/22/53, para 14, 64; Manfred Nowak & Elizabeth McArthur, 'The distinction between torture and cruel, inhuman or degrading treatment'. (2006) *Torture* 16(3), 147-51.

<sup>15</sup> Lori Ashcraft, Michele Bloss, & William Anthony, 'Best practices: The development and implementation of "no force first" as a best practice'. (2012) *Psychiatric Services*, 63(5), 415-417, 416; Dinesh Bhugre et al, 'The WPA-lancet psychiatry commission on the future of psychiatry'. (2017) *The Lancet Psychiatry*, 4(10), 775-818.

## Consumers labelled with SPMI can languish on CTO's for decades

27. Consumers labelled with SPMI often receive “Assertive Community Treatment”. In many instances, this occurs through Community Treatment Orders (CTOs).
28. Despite the original intentions of CTOs to improve human rights,<sup>16</sup> they have limited evidence supporting their efficacy,<sup>17</sup> and consumers continue to highlight their stigmatising and disempowering consequences.<sup>18</sup> These experiences can be worsened for Culturally and Linguistically Diverse individuals and First Nations people.<sup>19</sup>
29. For many consumers labelled with SPMI, CTOs reflect a totalizing control of their life. Regularly VMIAC hears members beg for ways to “get mental health services out of my life”. Unlike inpatient units, compulsory treatment under a CTO brings experiences of power and control into the home and community.
30. Our members report invasions of their privacy and security as health professionals routinely come to their home to “monitor” medication use. For parents and consumers with experiences of trauma and violence, these control mechanisms can be profoundly damaging.
31. Often it is not clear in policy proposals whether Assertive Community Treatment is intended to include compulsion or not. At VMIAC, we see no value in the use of compulsion in the community, and instead view the use of force as a human rights breach and a systems failure.
32. With effective advocacy and coordination (see [paras 75 to 80](#)), as well as real options, consumers will be supported to decide on less restrictive alternatives to compulsion.

### Recommendation

Any model of assertive community treatment should expressly exclude the use of Community Treatment Orders.

## Mental health services routinely ignore mental health laws, leading to further human rights violations

33. Setting aside our broad position on compulsory treatment, consumers consistently communicate that their rights under the MHA are not followed due to a failure of mental health services and psychiatrists to comply with their legislated duties.
34. Every day, thousands of clinical decisions are made by people working in the clinical mental health system which is governed by the MHA. To make lawful treatment decisions under the

<sup>16</sup> Lisa Brophy, et al, ‘Community treatment orders: towards a new research agenda’ (2018) *Australasian Psychiatry* 26(3), 299-302.

<sup>17</sup> Lisa Brophy, ‘Witness Statement 29 April 2020 to the Royal Commission into Victoria’s Mental Health System’ (2020) [14-20]; Jorun Rugkasa, ‘Effectiveness of community treatment orders: the international evidence’ (2016)

<sup>18</sup> Penelope Weller et al, ‘The need for independent advocacy for people subject to mental health community treatment orders’ (2019) *International journal of law and psychiatry* 66; Deborah Corring, Richard O’Reilly, and Christina Sommerdyk, ‘A systematic review of the views and experiences of subjects of community treatment orders’ (2017) *International journal of law and psychiatry* 74-80.

<sup>19</sup> Steve Kisely et al, ‘Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study (2020) 54(1) *Australian & New Zealand Journal of Psychiatry* 54(1), 76-88; Steve Kisely et al, ‘A systematic review and meta-analysis of predictors and outcomes of community treatment orders in Australia and New Zealand’ (2020) *Australian and New Zealand Journal of Psychiatry*, 1-16.

MHA, consultant psychiatrists and services must follow strict processes that are intended to provide safeguards for consumers. This is also an obligation under the Charter, with the right to liberty and security providing that liberty can only be restricted 'on grounds, and in accordance with procedures, established by law.'<sup>20</sup>

35. Failures to follow the *Mental Health Act 2014* (Vic) may give rise to the following human rights issues:

- a. Breaches of the right to liberty and security of person, by detaining and compulsorily treating consumers without legal authorization<sup>21</sup>
- b. Unlawful coercive and compulsory treatment decisions constituting torture or treatment that is cruel, inhuman, or degrading,<sup>22</sup> or exploitation, violence, and abuse<sup>23</sup> (see further **Annexure 2 – VMIAC Policy Position Paper #2: Preventing violence, abuse and neglect**)
- c. Breaches of consumers' physical and mental integrity to a greater extent than experienced by consumers not diagnosed with SPMI, which is discriminatory<sup>24</sup>

36. A failure to follow processes set out in the Act may render clinical decisions unlawful, and in turn give rise to numerous legitimate claims of human rights breaches.

37. VMIAC raises these duties because we see a systematic failure to follow them across all designated mental health services. In our wide and diverse experience, consultant psychiatrists and staff are not aware of or simply have no regard for their obligations under the MHA.

38. Consumers report, time and time again, that they are dismissed by psychiatrists and mental health services and have their rights ignored. This neglect and dismissal occur through the following mechanisms:

- a. **No consumer involvement** – Mental health professionals making decisions on behalf of consumers without their involvement, consultation, and/or consent. For example, this has been observed to occur routinely at handover meetings, "complex care committees", at nurses' stations, or Multiple and Complex Care Needs Initiative meetings.
- b. **Malleable 'least restrictive treatment' principle** – Determining that whatever treatment the psychiatrists originally proposed *is* the least restrictive treatment without regard to consumers' needs and preferences and little to no attempt to accommodate and respect these needs and preferences.
- c. **Presuming incapacity** – Contravening legislation by acting on the presumption that consumers diagnosed with SPMI lack the mental capacity to actively participate in decision-making regarding their treatment. An associated failure to undertake or document any decisional mental capacity assessments, nor treat such assessments as

<sup>20</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 21(3)

<sup>21</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 21(3)

<sup>22</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 10(a)-(b); *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 8 August 1989) art 1; *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*: opened for signature 24 January 2007, A/RES/61/106, art 15.

<sup>23</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*: opened for signature 24 January 2007, A/RES/61/106, art 16.

<sup>24</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*: opened for signature 24 January 2007, A/RES/61/106, art 17. For example, see: VMIAC, 'Seclusion report: how safe is my hospital?':

time-bound measures of a dynamic state (rather than enduring 'trait'), decision-specific, and generating responsibilities for treating teams to support consumers with time, information and resources to "regain" mental capacity and make their own decisions<sup>25</sup>

- d. **Failure to provide information** – Not providing consumers with the information, time, or answers to questions to make decisions or participate in decision-making about their own care<sup>26</sup>
  - e. **Chemical restraint** – In the early stages of inpatient admissions, consumers' regularly report high levels of sedation and restrictive practices used against them by psychiatrists. Instead of being supported to make decisions and participate in decision-making, consumers are frequently told that there are standard policies requiring all consumers to be kept in high dependency units. If consumers express a desire to discuss their treatment (e.g. medication regimen), such discussions are typically delayed on the grounds that consumers must "stabilise" before this can occur.
  - f. **Change of psychiatrists or treatment team** – Consumer requests for a different psychiatrist (e.g. of a different gender) are routinely ignored, without escalation or consideration by more senior psychiatrists.
  - g. **No statement of rights** – Instead of informing consumers of their rights and the service's obligations, psychiatrists routinely communicate that they will be making all decisions because of the consumer's treatment order.<sup>27</sup>
39. Each of these failures causes immeasurable harm and a loss of hope for consumers. Such failures also reflect non-compliance with measures designed to make treatment decisions lawful under the MHA.<sup>28</sup>
40. There are psychiatrists who are "known" to the consumer community as having a particularly strong disregard for consumers' human rights and their associated duties and responsibilities to uphold such rights under the MHA. Consumers have made advance statements for the sole purpose of preventing specific psychiatrists being involved in their treatment. This, however, sits aside the unfortunate reality that advance statements are routinely ignored.<sup>29</sup>
41. Thousands of Victorians are placed under compulsory treatment orders each year. Once on orders, safeguards for consumers rights' and legislation intended to ensure clinicians adequately perform their duties often prove ineffective.
42. Consumer experiences of isolation, disempowerment and oppression are routinised by a system in which the law simultaneously empowers psychiatrists and other mental health professionals to

<sup>25</sup> Contrary to *Mental Health Act 2014* (Vic) ss 68 & 70.

<sup>26</sup> See also: Chris Maylea et al, 'Evaluation of the Independent Mental Health Advocacy Service' (RMIT University, 2018), 18. This is contrary to *Mental Health Act 2014* (Vic) s 69(1)(b) & s 69(2)

<sup>27</sup> See also: Chris Maylea et al, 'Evaluation of the Independent Mental Health Advocacy Service' (RMIT University, 2018), 18.

<sup>28</sup> An independent review of IMHA found 'persistent and consistent breaches of peoples' rights and breaches of the Act, from failure to provide people with Statement of rights, to failure to involve people in decision-making processes, and the unlawful detention (sic), of consumers who were not subject to an order. The detention of consumers who were voluntary was commonly acknowledged by mental health professionals and, at times,

<sup>29</sup> Chris Maylea, Ann Jorgensen, Sarah Matta, Katherine Ogilvie and Paul Wallin 'Consumers' Experiences of Mental Health Advance Statements' (2018) *Laws* 7(2), 22.

abuse consumers, while failing to uphold the rights legislated to protect consumers from this very abuse.

### Recommendations

With priority given to [paras 22 to 32](#), eliminate compulsory treatment by ensuring:

- Transparent (publicly available) data sharing and measuring the use, duration, and consumer-rated outcomes of compulsory treatment, including disaggregated (de-identified) data on psychiatrists and identifiable data on safeguarding, monitoring and oversight bodies
- Substantial improvements in the regulatory framework to supporting compliance with interim mental health laws to:
  - Drive down and eliminate the use of force
  - Give regulatory visibility to, and oversight of, treatment decisions made under treatment orders
- Advance statements are given equal enforcement with the *Medical Treatment and Decisions Planning Act 2016* (Vic)
- Greater access to remedies under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and increased criminal penalties for human rights breaches and actions that constitute torture and ill-treatment

## Human rights cultures: mental health services, regulators, and the Department

43. The *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**) was intended to embed a human rights culture across Victoria through Parliamentary processes ensuring laws are compliant with the Charter, as well as obligations on “public authorities” to act compatibly with rights, and, in making decisions, give proper considerations to relevant rights.<sup>30</sup> It does not, however, give rise to a direct cause of action, nor damages for breaches of human rights.<sup>31</sup>
44. In a mental health context, this applies to the Department of Health and Human Services (DHHS), regulatory and oversight bodies such as the Mental Health Complaints Commissioner and Office of the Chief Psychiatrist, as well as designated mental health services that exercise a public function. These bodies, therefore, should rigorously consider the human rights implications of their decisions, so that they can act to uphold such rights in their work.
45. The legislated intent of the Charter has not matched VMIAC’s experience ‘on the ground’ where the law is supposed to be applied. Rather than a gradual evolution and implementation of human rights cultures and practice, we have observed a consistent and widespread disregard for human rights, or, at best, lip service after rights violations are reported.
46. For consumers labelled with SPMI who have multiple and enduring support needs, the impacts of this failure are particularly pronounced. For these consumers, actions by services, and a lack of action by Departments and regulators, mean they remain ensconced within compulsory mental health systems. This is not only costly to consumers, ironically, in terms of their mental health, but also expensive to the public purse.

## Mental health services

47. As public authorities, mental health services must act compatibly, and in making decisions, should show that they have had proper regard to the relevant Charter rights. This includes ensuring:
  - a. **Recognition and equality before the law** (s 8), such as when making decisions based on a mental health diagnosis, or other attributes such as gender, sexual orientation, or race<sup>32</sup>
  - b. **Protection from torture and cruel, inhuman, or degrading treatment** (s 10), such as preventing the unlawful use of force that causes physical and mental suffering
  - c. **Privacy and reputation** (s 13), such as preventing against the unlawful disclosure of information or interference with a consumer’s private life
  - d. **Freedom of thought, conscience, religion, and belief** (s 14), such as protections which protect against personal religious beliefs being uncritically pathologized as a “mental illness”<sup>33</sup>

<sup>30</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss38.

<sup>31</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss39.

<sup>32</sup> These attributes are also protected under the *Equal Opportunity Act 2010* (Vic). We also note that the failure to make reasonable adjustments for consumers, for example by providing inflexible service provision, may reflect indirect discrimination.

<sup>33</sup> See also *Mental Health Act 2014* (Vic) s 4(2)(b).



- e. **Freedom of expression** (s 15), including protections from reprisal for being critical of mental health services
  - f. **Right to liberty and security of person** (s 21), such as protections that cast doubts on the lawfulness of locked wards, for voluntary consumers,<sup>34</sup> and
  - g. **Humane treatment when deprived of liberty** (s 22), such duties on governments to provide gender-safe wards, irrespective of resources.<sup>35</sup>
48. Well implemented, these would form all aspects of mental health service design, delivery, and evaluation. Indicators of a mental health system based on human rights would be:
- a. The elimination of all forms of restrictive practice
  - b. Evidence of leadership, including consumer leadership, that understands and drives human rights compliance
  - c. Greater transparency over where human rights informs practice and funding of services
  - d. Greater consultation with consumers, such as Consumer Consultants and Consumer Advisory Groups, on improving compliance with human rights
  - e. Evidence of human rights embedded in models of care, complaints management as well as legal compliance and performance management frameworks.
49. Reporting on these indicators and measures of compliance with the Charter rights or appropriate consideration of Charter rights is critical to embedding a human rights culture.
50. VMIAC are, as yet still waiting on measures and indicators such as these. Instead, we continue to hear from consumers about human rights violations within services.
51. Part of this has been the lack of meaningful support for consumer leadership within mental health services to identify and work through key human rights issues. The final report presents an opportunity to acknowledge this and embed roles for consumer leadership and human rights practice in all aspects of service design, delivery and evaluation.

## Regulatory and oversight bodies

52. Regulatory and oversight bodies must also act compatibly with the Charter.
53. For example, the Mental Health Tribunal (**MHT**) must interpret all statutory provisions consistently with the Charter. Charter rights that are particularly relevant to the MHT are similar to those noted above.<sup>36</sup> In practice, however, we note that the human rights have little impact on MHT decision-making. To the extent that human rights are referred to in a Statement of Reasons, they appear more like considerations than their reality as binding obligations.
54. This also applies to other regulatory bodies, such as the Office of the Chief Psychiatrist (**OCP**). The OCP, whose role is to promote the rights of consumers,<sup>37</sup> has also failed to demonstrate proper regard for the Charter.

<sup>34</sup> Given the limited evidence supporting locked wards, VMIAC views this as an unjustifiable restriction on rights under the Charter.

<sup>35</sup> Human Rights Committee, *General Comment No 21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty)*, 46<sup>th</sup> Session, HRI/EN1/Rev.9 (Vol 1), [4].

<sup>36</sup> For discussion of these rights, see: *PBU & NJE v Mental Health Tribunal and Others* (2018) 65 VR 141, 83 -132.

<sup>37</sup> *Mental Health Act 2014* (Vic) s 120(c)

55. For example, of the 29 Chief Psychiatrist guidelines developed or updated since the Charter came into effect, only 6 mention the Charter.<sup>38</sup> The following guidelines, which have particular relevance to people labelled as having SPMI and with multiple and enduring support needs, have no reference to the Charter:

- a. **“Inpatient leave of absence”**, where consumers have restrictions on their movement, while also reporting that they feel unsafe in inpatient units
- b. **“Mental health services and supported residential services”**, where consumers report violence, abuse, and neglect, as well as financial exploitation due to unreasonable pricing
- c. **“Reducing adverse medication events in mental health services”**, where consumers report that their quality of life and long-term health are negatively impacted by medications
- d. **“Restrictive interventions in mental health services”**, where there are obvious implications for bodily integrity and autonomy, and
- e. **“Treatment plans”** which relate to a broad range of human rights relating to autonomy, liberty, and humane treatment when deprived of liberty.

56. A key purpose of regulation is to promote “goods” and limit “harms”.<sup>39</sup> Consumers are consistently highlighting the harmful impacts of human rights abuses, and yet this does not appear to take precedence in regulatory activities, such as in the use of powers by key regulators.

57. This breakdown is the result in part, due to a lack of consumer leadership in regulation of services and systemic advocacy. As we note in [paras 123 to 128](#), consumer leadership should underpin all of a regulator or oversight body’s activities.

## Government departments

58. Within government, VMIAC sees mentions of the Charter and human rights, but we do not see it routinely operationalised into work. For example, we do not see an embedding of human rights in the:

- a. development of systems-wide objectives, such as comprehensive funded strategies to reduce and eliminate compulsory treatment
- b. funding of research and development projects, such as human-rights focused projects and research grants
- c. continuous improvement measures, such as assistance for mental health services to embed human rights in their quality improvement and clinical practice frameworks
- d. compiling and sharing of data, such as on compulsory treatment
- e. systems performance monitoring, such as of specific health services against human rights standards

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<sup>38</sup> We note that this desktop review did not examine whether the Charter had been adequately implemented through this mention.

<sup>39</sup> See Malcolm Sparrow, *The Character of harms: Operational challenges in control* (Cambridge University Press, 2008); Malcolm Sparrow, *The regulatory craft: controlling risks, solving problems and managing compliance* (Brookings Institution Press, 2000).



- f. mental health promotion and prevention, such as those which promote the human rights and participation of consumers labelled with SPMI
  - g. interdepartmental integration to address social determinants of mental health, and
  - h. workforce funding and capability development, such as mandatory human rights training.
59. At each of these moments Charter rights are routinely engaged, but seldom influence decision-making. Various departments and/or managers of the mental health system should embed human rights at each of these aspects.
60. In implementing these Charter rights, government departments must also be keenly aware that consumer leadership and involvement is both valuable, and required under the *Convention on the Rights of People with a Disability*.<sup>40</sup> Therefore consumer leadership should reflect a general throughput rather than tack-on to any future measures.

### Recommendation

That recommendations and Charter commentary make it clear that human rights need to be implemented in all aspects of the mental health system, including in its design, funding, delivery, and evaluation.

That section 39 of the Charter is reformed so that consumers who experience human rights breaches enjoy a direct cause of action and remedies such as damages.

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<sup>40</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly: opened for signature 24 January 2007, A/RES/61/106, art 4(3).*

## Our physical health is harmed by the system

61. Our members who are labelled with SPMI are likely to die 30 years younger than the rest of the Australian community.<sup>41</sup>
62. This is despite our right to health under both the International Covenant on Economic, Social and Cultural Rights (ICESCR) as well as the Convention on the Rights of People with a (CRPD).<sup>42</sup>
63. In our practice experience, we see three interlinking causes:
- a. **Detention** – consumers continue to be detained in inpatient units as well as Secure Extended Care Units (SECUs). This impacts their ability to move and exercise.
  - b. **Psychotropic medications** – despite compelling evidence about the disabling and negative health outcomes for consumers,<sup>43</sup> they continue to be prescribed, often compulsorily.
  - c. **Limited healthcare** – consumers regularly report that their physical healthcare is not adequately cared for in mental health settings, due to “diagnostic overshadowing”,<sup>44</sup> a lack of self-referral mechanisms, and limited health expertise (particularly in remote settings).
64. Given the greater prevalence of detention and compulsory medication, it is not surprising that this disproportionately affects consumers labelled with SPMI.
65. VMIAC notes the important work underway through the Equally Well physical health framework,<sup>45</sup> but caution that this needs to be implemented into service delivery, with standards integrated into accreditation and regulatory frameworks.
66. In addition to effectively implementing the Equally Well framework, the Royal Commission may consider the following to better prevent and respond to physical health issues during mental healthcare:
- a. **Unlock inpatient wards** – there is limited evidence supporting locked wards,<sup>46</sup> and greater access to outdoors and exercise would support consumers’ physical wellbeing
  - b. **Prohibit treatment that unduly impacts physical health** – there should be legislative obligations that a psychiatrist cannot prescribe psychotropic medications that risk unduly harms a consumers’ physical health, unless the consumer has consented to this<sup>47</sup>

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<sup>41</sup> Joanne Suggett, Kim Foster, Vinay Lakra, Michael Steele, and Trentham Furness ‘Natural cause mortality of mental health consumers: a 10-year retrospective cohort study’ (2020) *International Journal of Mental Health Nursing*.

<sup>42</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly: opened for signature 24 January 2007, A/RES/61/106, art 25.*

<sup>43</sup> Mental Health Commission of NSW (2015). *Medication and Mental Illness: Perspectives*. Sydney, Mental Health Commission of NSW; Victoria Legal Aid, ‘Your Story, your say: Consumers’ priority issues and solutions for the Royal Commission into Victoria’s Mental Health System’ (Victoria Legal Aid, 2020); Marc De Hert, Johan Detraux, Ruud Van Winkel, Weiping Yu, and Christoph Correll, ‘Metabolic cardiovascular adverse effects associated with antipsychotic drugs’ (2012) *Nature Reviews Endocrinology* 8(2), 114-126; ALP ÜÇÖK & Wolfgang Gaebel, ‘Side effects of atypical antipsychotics: a brief overview’. (2008) *World psychiatry*, 7(1), 58-62; Dr Kate Dorozenko & Dr Robyn Martin, *A Critical Literature Review of the Direct, Adverse Effects of Neuroleptics. Essential Information for Mental Health Consumers, Carers, Families, Supporters and Clinicians*, (Australia, NMHCCF, 2017). Retrieved from: <https://nmhccf.org.au/publication/critical-literature-review-direct-adverse-effects-neuroleptics>

<sup>44</sup> Brenda Happell, Stephanie Ewart, Julia Bocking, Chris Platania-Phung, and Robert Stanton, ‘That red flag on your file’: misinterpreting physical symptoms as mental illness’ (2016) *Journal of clinical nursing* 25(19-20), 2933-2942.

<sup>45</sup> Department of Health and Human Services, *Equally well in Victoria: Physical health framework for specialist mental health services* (Department of Health and Human Services, Victorian Government, 2019).

<sup>46</sup> Christian Huber & Andres Scheenberger, Eva Kowanlinski et al, ‘Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15 year observational study’ (2016) *The Lancet Psychiatry* 3(9), 842-849.

<sup>47</sup> For example, this could be reflected in the mental health principles.

- c. **Better enable access to health supports** – including improved referral pathways (include self-referrals), better mechanisms to enable engagement with general practitioners and other private health providers for consumers, on-site visits from health practitioners, and improved tele-health options.

#### **Recommendation**

In addition to implementing and funding the Equally Well physical health framework, undertake reforms that:

- Prohibit locked ward practices
- Prohibit treatment that unduly impacts a consumers' physical health, unless they consent
- Create better pathways for physical health supports, and
- Any new infrastructure spending must mandate access to outdoor amenities.

## Improving child-protection services

67. VMIAC hears of the negative impacts that Child Protection services have on children and parents labelled with SPMI.
68. In many cases, rather than helping, families and parents report the Child Protection worsened their situation.<sup>48</sup> The failure to appropriately engage with families leads to removal of children, that disproportionately affect Aboriginal families.<sup>49</sup>
69. Our practice experience highlights this in the context of mental health, with consumers who are parents reporting stigma and discrimination from Child Protection services. For example, some consumers are told that they will not see their children unless they “develop insight” into their mental illness.
70. As a result, mental health and Child Protection services come to work alongside one another. Rather than providing holistic support, this comes to reflect another mechanism of control over consumers’ lives. In some cases, parents labelled with SPMI are subject to coercion by these services. This is particularly problematic given the experiences of gender-based violence that many women in mental health settings have experienced.<sup>50</sup>
71. Such issues give VMIAC caution regarding calls for “universal screening” of parents and children for mental health issues. We are aware this has been advocated for by some mental health advocates and professionals.<sup>51</sup> While we favour early supports being provided to parents given the difficulties early parenthood can present, and the mental health outcomes that stem from this, this should be governed within a human rights framework to protect against the risk of greater surveillance. In a human rights-based approach, parents would be offered early supports such as voluntary counselling and mental health supports, but also peer support,<sup>52</sup> advocacy and other services that parents identify that they need.
72. To safeguard against these experiences of control by services, we highlight the value of advocacy. Examples such as the Independent Family Advocacy Support Service assist parents in the early stages of child protection and have been positively received by consumers who have used their services, and have a significant return on investment in diversion from Child Protection litigation. They are, however, currently only able to provide a limited form of self-advocacy service to parents with a mental health issue, as opposed to more intensive and direct forms of advocacy devoted to Aboriginal and/or Torres Strait Islander parents or parents with an intellectual disability.<sup>53</sup>

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<sup>48</sup> Commission for Children and Young People, ‘In our own words’: Systemic inquiry into the lived experience of children and young people in the Victorian out-of-home care system (Melbourne: Commission for Children and Young People, 2019).

<sup>49</sup> Victorian Aboriginal Children & Young People’s Alliance, *Submission to the Royal Commission into Victoria’s Mental Health System* (Submission to the Royal Commission into Victoria’s Mental Health System, July 2019).

<sup>50</sup> Australia’s National Research Organisation for Women’s Safety, ‘Preventing Gender based violence in Mental Health Units’ (ANROWS, July 2020), 11, 16.

<sup>51</sup> The Royal Australian and New Zealand College of Psychiatrists: Report from the Faculty of Child and Adolescent Psychiatry. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, 2010; Perinatal Anxiety and Depression Australia, ‘Submission to the Royal Commission into Victoria’s Mental Health System’ (*Submission to the Royal Commission into Victoria’s Mental Health System*, July 2019).

<sup>52</sup> We note co-designed services such as the Family by Family program, that helps families in crisis resolve their issues without Child Protection involvement: Michael Mintrom & Joannah Luetjens, ‘Design Thinking in Policymaking Processes: Opportunities and Challenges’ (2016) *Australian Journal of Public Administration* 75(3), 391-402, 397.

<sup>53</sup> Chris Maylea; Thomas, Sherie; Bashfield, Lucy; Kuyini, Bawa; Costello, Susie; Singh, Meena (2020) *Midterm Evaluation of Independent Family Advocacy and Support (IFAS) pilot*, Melbourne: Social and Global Studies Centre, RMIT University.

73. Expansion of services such as these have had significant benefits for consumers as well as return on investment in avoiding substantial Child Protection intervention.

**Recommendation**

Ensure that all reforms that impact children and parents labelled with SPMI operate within an explicit human rights framework.

Ensure that early supports provided to parents extend beyond medical supports, to social, peer and other supports.

Expand funding to advocacy services for parents with mental health issues, such as the Independent Family Advocacy Service.

## Coordinating multi-agency supports based on human rights

75. Many consumers labelled with SPMI are told that they require long-term multi-agency supports. The intention in such circumstances is often to provide “wrap around” supports for consumers. However, consumers do raise several issues or risks with this approach.
76. For many consumers, the presence of multiple services increases feelings of disempowerment. Decades of practice experience has reminded VMIAC and its members how care coordination can be structured around the needs of services, rather consumers. Care coordination meetings provide an example, often involving child-protection, housing, clinical and non-clinical mental health supports as well as family and carers. In many cases, consumers become silent witnesses to their own meeting, with no input on the agenda, invitees, supports as well as meeting location. These power dynamics are worsened in the context of compulsory treatment.
77. Any multi-agency supports, and their coordination should promote citizenship and human rights, rather than undermine them. There should be an explicit focus and safeguards to ensure the coordination:
- a. Supports recovery as a personal journey<sup>54</sup>
  - b. Upholds supported decision-making frameworks, so that consumers, if they want/require support, are given it, to coordinate their own care,<sup>55</sup> and
  - c. An understanding and response to the social determinants of health, including acknowledging and responding to a person’s legal needs
78. Many consumers will be able to communicate and direct services on their views and preferences. However, this can become more difficult in the context of compulsory treatment. Equally, other consumers may have their attention focused on other matters or have difficulties in communicating.
79. In these instances, consumers should be offered support to coordinate their care, rather than lose control over that coordination.
80. This can be addressed, in part, more effective coordination that utilises representational advocacy models, such as those used by VMIAC and Independent Mental Health Advocacy. Models more directly relevant to care coordination, that the Commission may draw on are:
- a. The Personal Ombuds scheme<sup>56</sup>
  - b. Partners in Recovery<sup>57</sup>

<sup>54</sup> When consumer-survivors are asked about what recovery means to them, they highlight the need **for connectedness, hope, identity, meaning-making and empowerment**: Mary Leamy, Victoria Bird, Clair Le Boutillier, Julie Williams and Mike Slade, 'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis' (2011) *The British Journal of Psychiatry* 199(6), 445-452.

<sup>55</sup> By contrast, Tom Arnkil has provided the Open Dialogue approach to interagency meetings, where the person whose life it is brings along someone (e.g. a friend, family member or other support of their choosing) who is encouraged to be a support/helper in the space. A dialogue is facilitated that is strengths based and follows other ethical principles such as acknowledging worries, non-coercive practice from professional agencies, and promotion of the person’s control. See: Tom Arnkil, *Dialogical meetings in social networks* (Routledge, 2018).

<sup>56</sup> See Piers Gooding, Bernadette McSherry, Cath Roper, and Flick Grey, *Alternatives to coercion in mental health settings: A literature review* (Melbourne Social Equity Institute, 2018), 204.

<sup>57</sup> The core role of support facilitators is to assist consumers to identify and access services they want and assist in the coordination of those services. It was designed to deal with the fragmentation of many mental health support services: Nicola Hancock, Justin Newton Scanlan, James Gillespie, Jennifer Smith-Merry, Ivy Yen, 'Partners in Recovery program evaluation: changes in unmet needs and recovery' (2018) *Australian Health Review* 42, 445-452.

**Recommendation**

That human rights and supported decision-making are reflected in multi-agency supports through:

- Improved models of care coordination, and
- Increased access to advocacy for care coordination.

## Long-term units: standards of care & human rights

What (if anything) do consumers raise with VMIAC as working well currently/what have consumers said they would like to see more of (including in relation to Secure Extended Care Units (SECUs) and Community Care Units (CCUs))?

If consumers with multiple and enduring support needs are in long-term residential care, such as SECUs, or CCUs, what:

- could be done to ensure the greatest standard of care, as determined by the consumers?
- could be done to best protect their human right?

### SECUs and CCUs

81. We are yet to hear positive feedback about SECUs or CCUs but understand that some consumers may find these services helpful.

### Differentiating SECUs from CCUs

82. It is important to note the significant differences between these services. Unlike CCUs, consumers can be detained in SECUs compulsorily, often for years.
83. We also note that the purpose of SECUs has becoming increasingly unclear in recent decades. In theory we note that SECUs are being discussed in terms of “rehabilitation”. This messaging, however, is unclear, with DHHS providing that consumers in this setting tend to:
- a. ‘have difficulty living in the community or a less restrictive environment due to behavioural disturbances
  - b. Lack the capacity to live independently
  - c. Be at high risk of harm to themselves or others
  - d. Have comorbidities, including drug and alcohol problems, acquired brain injury or intellectual disability.’<sup>58</sup>
84. When articulating the purpose of admissions to SECUs, DHHS articulates a key aim is to ‘contain’ compulsory patients.<sup>59</sup>
85. This at odds with recovery, strengths-based and human-rights-focused approaches to mental and emotional distress. Furthermore, some consumers currently spent over 15 years in SECUs detention, which suggests that the process of deinstitutionalisation remains incomplete.
86. In improving these services, the Royal Commission should reset the purpose for long-term care, towards a human rights and recovery-oriented framework.

### Recommendation

Approach SECUs reform with the aim of fundamental change by:

- Explicitly stating an end to institutionalising forms of treatment and detention

<sup>58</sup> Department of Health and Human Services, ‘Secure extended care units’ *Vic Health (online)* (accessed 1 November 2020) <<https://www2.health.vic.gov.au/mental-health/mental-health-services/services-by-type/subacute-mental-health-services/secure-extended-care-units>>

<sup>59</sup> Id.



- Clarifying the scope and purpose of SECUs, as distinct from CCUs and PARCs.

## Improving standards of care

87. There is significant variation in the quality of SECU and CCU services. Areas that could be improved include:

- a. **Improving facility design** – improving the therapeutic design and accessibility of units (including to outdoor areas and parkland).
- b. **Technology** – improving ICT and tele-health capacities within services.
- c. **Improving clinical notes** – ensuring that improvements to access to, and collaboration on, clinical notes (co-written notes).
- d. **Peer work** – dramatically expand peer support in these settings.

88. These improvements should be made by the systems manager or relevant department, with consumer leadership embedded at every stage. These standards should be integrated with accreditation as well as regulation and oversight processes.

### Recommendation

Ensure a new model of care for SECUs and CCUs highlights the need for standards to improve facility design, ICT, clinical notes access, and peer work standards. These standards should be co-produced by the Systems Manager with consumers.

## Establish diversionary pathways away from SECU

89. There should be diversionary pathways to respite centres and less restrictive alternatives than CCU's and in particular SECUs.<sup>60</sup>

90. Currently there is a lack of less-restrictive options than SECU and CCU's for consumers who would seek or are compelled to have long-term residential or inpatient care.

91. Consumers should be given opportunities to consider less restrictive alternatives to these forms of residential and acute inpatient settings. These can include access to:

- a. Community mental health and peer support services
- b. Respite, including peer-led respite, services
- c. Practical in-home support services for consumers that identify challenges to managing daily activities, and
- d. Step-up and step-down services, such as Prevention and Recovery Centres.

92. Clinicians should not be gatekeepers of this information, nor decision-makers about whether these less restrictive alternatives are appropriate. Therefore, self-referral opportunities and mechanisms should be built into models of community and inpatient care.

<sup>60</sup> As SECUs are treated as inpatient units, meaning that a person can be detained there under the *Mental Health Act 2014* (Vic).

93. If consumers are considering SECU or CCU, there should be formal obligations on consumers undertaking a site visit prior to making this decision.<sup>61</sup>

#### Recommendation

Ensure that consumers have access to less restrictive alternatives to SECU. Models of care for SECU should clarify that less restrictive alternatives must be offered to consumers before SECU has been considered.

Ensure that consumers considering SECU or CCU care are provided with the option to visit prior to making their decision.

### Establish formal housing pathways

94. Consumers' discharge into the community is often delayed by housing issues. This can be a lack of a fixed address to be discharged to, or that there are problems with the existing housing arrangement, such as the conditions, which may have worsened while the person was in detention.
95. In any public housing reforms, primacy should be given to consumers who have accessed the clinical mental health system, as they are at greater risk of experiencing homelessness and further homelessness.
96. This may be assisted by co-location of relevant housing workers within clinical mental health services, to ensure that this prioritisation process is implemented in practice.

#### Recommendation

Ensure that consumers labelled with SPMI enjoy prioritisation in accessing housing, by:

- Explicitly prioritising them in housing registers
- Co-locating housing service providers within clinical mental health services.

### Review model of care & governance to bring into alignment with human rights

97. VMIAC regularly hears that bed-pressure is a primary cause for breaches of human rights and the MHA. Unfortunately, our members report these same human rights breaches in long-term settings, highlighting deeper cultural and structural flaws in mental health services.
98. SECU and CCU services should develop local action plans to demonstrate how their service complies with standards, including:
- a. The *Charter of Human Rights and Responsibilities Act 2006* (Vic)
  - b. Mental health laws, should they continue
  - c. *Health Services Act 1988* (Vic) (see further [paras 133 to 141](#))

<sup>61</sup> We note that consumers' experiences of SECUs and CCUs are often different than that portrayed by their treating clinician.

99. These action plans should reflect an extension of accreditation processes that also require that services be measured against key human rights and consumer indicators. Approaches such as this reduce fragmentation in systems management and regulatory activities.
100. This should form part of a broader co-produced review of the model of care, undertaken by the systems manager, for services such as CCU's, SECUs and PARCs to ensure it is based on and/or inclusive of:
  - a. Supported decision-making
  - b. Recovery, and
  - c. First Nation's approaches to social and emotional wellbeing frameworks.<sup>62</sup>
101. Within this model should include a provider of last resort for people who can't access the NDIS but require supports to be discharged from SECU.

### Recommendation

Review models of care for SECUs, CCUs, and PARC's (separately), to ensure that they align with human rights, recovery, supported decision-making frameworks as well as First Nation's approaches to social and emotional wellbeing.

### Enhancing legal and non-legal advocacy

102. Legal and non-legal advocacy is critical to redressing power imbalances and embedding supported decision-making.<sup>63</sup>
103. VMIAC considers the following services critical to consumers in SECU and CCU:
  - a. **Independent Mental Health Advocacy**,<sup>64</sup> which provides non-legal advocacy to consumers on compulsory treatment orders. VMIAC supports an opt-out IMHA service.<sup>65</sup>
  - b. **Legal advocacy services**, provided predominantly by Victoria Legal Aid and the Mental Health Legal Centre, for consumers wanting advice relating to mental health and disability law
  - c. **Independent Family Advocacy Service**,<sup>66</sup> which services parents who are involved in the early stages of child-protection proceedings, but is currently not funded to assist people with a mental health diagnosis, and
  - d. **Non-legal advocacy for discrimination**, consumers experience discrimination in various aspects of public life. Non-legal advocacy for people with direct lived experience experiencing discrimination can assist full participation in public life.<sup>67</sup>

<sup>62</sup> Such as those outlined in the Balit Murrup: State Government of Victoria, *Balit Murrup: Aboriginal social and emotional wellbeing framework: 2017-2027* (2017).

<sup>63</sup> Karen Newbigging, Julie Ridley, Mick McKeown, Karen Machin, & Konstantina Poursanidou, "'When you haven't got much of a voice': an evaluation of the quality of Independent Mental Health Advocate (IMHA) services in England". (2015) *Health & social care in the community*, 23(3), 313-324.

<sup>64</sup> Chris Maylea et al, 'Evaluation of the Independent Mental Health Advocacy Service' (RMIT University, 2018)

<sup>65</sup> See further: VMIAC Policy Position Paper #1: Compulsory treatment (Annexure 1)

<sup>66</sup> See independent review: Chris Maylea; Thomas, Sherie; Bashfield, Lucy; Kuyini, Bawa; Costello, Susie; Singh, Meena (2020) Midterm Evaluation of Independent Family Advocacy and Support pilot service (IFAS), Melbourne: Social and Global Studies Centre, RMIT University

<sup>67</sup> For reviews of this, see: Maria Karras, Emily McCarron, Abigail Gray, and Sam Ardasinski, 'On the edge of justice: the legal needs of people with a mental illness in NSW'. (*Law and Justice Foundation of NSW, Sydney*, 2006), 165-189.

104. Wherever possible, these services should be expanded given the compounding forms of disadvantage and marginalisation faced by consumers in SECUs and CCUs.

### **Recommendation**

Enhancing legal and non-legal advocacy for consumers labelled with SPMI.

## **Improving access to the NDIS**

105. Despite the original vision, the NDIS is yet to comprehensively enable choice and control. For consumers in SECU, accessing an NDIS package can enable them to be discharged sooner.
106. We note however, that there is often a lack of information and support for consumers as part of the application process, meaning consumers often seek assistance from allied health workers at SECUs. This assistance may become problematic due to inherent power imbalances between consumers and SECU staff. Examples VMIAC has come across in their work include that SECUs:
- a. Can assume choice and control by determining which services the person needs for them to be released from their inpatient order
  - b. Are the gatekeepers for much of the relevant clinical information that consumers need to substantiate their NDIS application, and
  - c. Often risk institutionalising consumers, whereas the NDIS, ostensibly, is intended to provide choice and control. These can be jarring differences which make accessing the NDIS more difficult.
107. Taken together, these factors can become sources of disempowerments and points of leverage for coercion for consumers, contrary to the original intent of the NDIS.
108. Non-legal advocacy, as provided by VMIAC, provides a mechanism to address this. At present we lack the capacity to provide outreach to SECU services across the State. With greater capacity, VMIAC's NDIS advocacy team could assist consumers to engage with the NDIS and fast-track their release from SECU and CCU services.

### **Recommendation**

Enhance access to NDIS for consumers in SECU by providing independent advocacy.

## Oversight & Consumer Leadership

What oversight mechanisms are necessary where a person has multiple and enduring support needs to:

- ensure the greatest standard of care, as determined by the consumer?
- best protect their human rights?

Consumer leadership is something the Commission is considering across its work streams – what role do you see for consumer leadership in the multiagency supports that may be offered when a person has multiple and enduring support needs?

### How we approach regulation, monitoring and oversight

109. VMIAC approaches monitoring, regulation and oversight from the perspective that it must operate in the public interest, and that notions of public interest should be heavily shaped by experiences and outcomes sought by consumers who use regulated mental health services.
110. At VMIAC, we have shared our members' concerns about the monitoring and oversight systems in Victoria, and in May 2020 presented to the Royal Commission. We are aware that this reflects feedback other consumers have provided about safeguarding and oversight bodies.<sup>68</sup>

### Understand the operating context for regulation and oversight

111. In order to prevent the mental health system and oversight bodies relapsing to its current practice, it is critical that recommendations and assertive commentary in the final report integrate and name the current issues in the existing regulatory and oversight system. These factors include:
- a. **Power asymmetries** – except for VMIAC, consumers labelled with SPMI have very few mechanisms to advocate to regulators to meet their outcomes. By contrast, regulators have regular and ongoing contact with quality managers and clinical directors of designated mental health services. This asymmetry enables mental health services, through their routine regulatory conversations with oversight bodies, to create cultures of denial and excuse for human rights abuses.
  - b. **Lack of independence** – this leads to a lack of independence of these safeguarding and oversight bodies, including a loss of faith in them by the consumer community.
  - c. **Current risk-based regulation is undermining human rights** – in our engagements with services, we learn that while there is significant rhetoric devoted to human rights by regulators, the devotion and strength of regulatory activities favour clinical approaches based on conservative risk assessments. If risk-based regulatory frameworks embedded human rights as something that needed to be regulated against, then greater balance

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<sup>68</sup> Victoria Legal Aid, 'Your Story, your say: Consumers' priority issues and solutions for the Royal Commission into Victoria's Mental Health System' (Victoria Legal Aid, 2020), 16-17.

may be found. This is despite obligations on the State to create monitoring mechanisms to prevent torture and ill-treatment, as well as to implement the CRPD.<sup>69</sup>

- d. **Regulation is reactive** – the current regulatory scheme is skewed towards reactive complaints-based systems and appears unable or unwilling to address human rights issues as they arise. This requires consumers to undergo trauma and human rights violations before regulators are empowered or willing to act.
- e. **Inactivity warrants attention** – the *failure* to undertake regulatory more assertive actions by key regulators is as noteworthy as the actions it *has* taken.<sup>70</sup> The absence of assertive human rights-based regulation clears the way for ongoing abuse of consumers.
- f. **Monitoring and oversight lacks transparency** – regulatory activities, including the data that arises from those activities, remain kept away from the public. This restricts the ability of consumers, allies, and services to drive quality improvement within services. This is despite obligations for civil society and people with direct lived experience to be involved in the process.<sup>71</sup>

112. These issues give rise to a broad range of recommendations to address regulation and oversight. In the following VMIAC provides:

- a. Specific recommendations for oversight of the coordination of multi-agency supports, and
- b. More general recommendations for regulation and oversight of mental health services that engage with consumers labelled with SPMI.

## Monitoring and oversight for multi-agency supports

113. The involvement of multi-agency supports requires considered monitoring and oversight. This is because, as noted in [paras 75 to 80](#), consumers can experience compounding forms of marginalisation as services naturally assume control of coordination processes.

114. Monitoring and oversight supports will be critical to ensure that the coordination of multi-agency supports – as opposed to the services themselves – is:

- a. Based on human rights
- b. Supported decision-making, and
- c. Recovery.

115. To do so, the following features are critical:

- a. **Consumers must be present** – consumers must be present at all decisions about the coordination of their care. There should be expressed rules preventing out-of-session decisions being made about the coordination of care without a consumer's knowledge or involvement.
- b. **Consumer and human rights representation on committees** – any oversight committee to oversee the coordination of care must have consumer representation as well as human rights expertise.

<sup>69</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*: opened for signature 24 January 2007, A/RES/61/106 art 33(2).

<sup>70</sup> John Kendall, 'Custody visiting: The watchdog that didn't bark' (2020) *Criminology and Criminal Justice* 1-17.

<sup>71</sup> *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*: opened for signature 24 January 2007, A/RES/61/106 art 33(3).

- c. **Human rights-based coordination** – coordination of consumer care must be based on representational advocacy and/or supported decision-making, so that consumers can exercise their legal capacity to coordinate their own care, as outlined in [paras 75 to 80](#). They may also benefit from increased access to advocacy, as opposed to care coordination, as outlined in [paras 102 to 104](#).
- d. **Independent evaluation** – there should be an independent co-produced evaluation of multi-agency coordination arrangements within 3 years of commencement to identify whether they are achieving their intended purpose.
- e. **Ensuring pathways for complaints** – there should be explicit pathways for consumers to make complaints about: 1) the coordination of their care; and 2) the specific providers of care. These pathways should be clarified and made user-friendly for consumers.

### Recommendation

Ensure that monitoring and oversight of service coordination safeguards human rights, recovery and supported decision-making.

Ensure that any model of care coordination should be reviewed, through a co-production methodology, within three years of commencement.

## Broader themes in regulation and oversight

116. To improve regulation and oversight of mental health services that intersect with this group of consumers, VMIAC recommends the Royal Commission:
- a. Improve and integrate accreditation (see [paras 87 to 88](#))
  - b. Improve data sharing
  - c. Promote consumer leadership in regulation and oversight
  - d. Design for strong leadership
  - e. Guard against regulatory failure
  - f. Articulate implementation expectations from services

## Sharing data and information for change

117. Information management is crucial to reforming market-based systems.<sup>72</sup>
118. The idea of “consumers” rests upon the ability of individuals to make decisions with the necessary information.<sup>73</sup> With appropriate information and supports, consumers and civil society can be part of the regulatory process.<sup>74</sup>
119. However, information asymmetries between consumers, and services, governments and regulators have maintained the current system. For example, consumers and advocates currently do not have ready or meaningful access to the following service-level data:

<sup>72</sup> Cass Sunstein, ‘Empirically informed regulation’ (2011) *University of Chicago Law Review* 8(4), 1349-1429.

<sup>73</sup> Arie Freiberg, *Regulation in Australia 2<sup>nd</sup> Edition*, (Federation Press, 2017), 331.

<sup>74</sup> Judith Healy, ‘Patients as regulators in their own healthcare’ in Peter Drahos, *Regulatory Theory: Foundations and Applications* (Australian National University Press, 2017), 591-610.



- a. complaints data, including recommendations made to services (and their implementation status)
  - b. compulsory treatment data, and
  - c. Accreditation results (nor are they consulted during accreditation).
120. Consumers also lack information at an individual level that can inform their treatment decisions, including:
- a. Independent health information on treatment options, including from consumers who have used similar treatments
  - b. Statement of rights, explained in ways and at times that are meaningful and accessible to them<sup>75</sup>
  - c. Information on the available clinicians and psychiatrists, so they can choose them, like consumers would in a traditional marketplace, and
  - d. Information on mental health services, including how they have been reviewed and/or evaluated by consumers.
121. This information should be made available to create the choice architecture for consumers to make their own decisions about treatment and safeguard their rights
122. The above relates to **access** asymmetries, but in mental health, there are critical asymmetries in the **production** of information via clinical notes and other measures. Consumers have consistently reported concerns about the notes that are written about and produced at Mental Health Tribunal Hearings. As highlighted in [para 87](#)), co-written notes should be trialled with consumers.

### Recommendation

Approach information sharing and publication with the intention to redress information asymmetries between consumers and other stakeholders, such as clinicians, service providers or governments.

## Bring consumers and consumer leadership into the oversight process

123. People with lived experience are instrumental to safeguarding and oversight problems. Consumers in mental health services, who have experience of detention, can provide expertise that people who have not gone through detention cannot, including:
- a. Being able to identify issues that others cannot<sup>76</sup>
  - b. Better at identifying cultural issues within services<sup>77</sup>
  - c. Challenging assumptions that may have previously been part of regulatory and oversight processes<sup>78</sup>

<sup>75</sup> Chris Maylea et al, 'Evaluation of the Independent Mental Health Advocacy Service' (RMIT University, 2018).

<sup>76</sup> Steven Caruana, 'Enhancing best practice inspection methodologies for oversight bodies with an Optional Protocol to the Convention against Torture Focus: Report to the Winston Churchill Memorial Trust of Australia' (*The Winston Churchill Memorial Trust*, 2018).

<sup>77</sup> In prison setting, see for example: 3 Stevens, Jem, Institutional culture in detention: a framework for preventive monitoring, Penal Reform International and the Association for the Prevention of Torture (2015) 19.

<sup>78</sup> Such as the capacity of consumers to make decisions, or about the accessibility of complaint processes: Association for the Prevention of Torture, Jean-Jacques Gautier NPM Symposium 2016 Monitoring psychiatric institutions Outcome report (2016)



- d. for example, by identifying cultural changes required in services.<sup>79</sup>
124. It will also be critical that consumers and the consumer community enjoy an independent Systemic Consumer Advocate or Commissioner to hold government and services to account. Among other things, this consumer role should be:
- a. Strictly separate from government and other agencies
  - b. Given its own budget and operational autonomy
  - c. Granted powers to undertake inquiries and to table reports in Parliament and require a response from the relevant Minister, and
  - d. Reporting to the Premier on all aspects of the system that interact with people with lived experience, such as police and housing.
125. Such an approach will be necessary to:
- a. Have credibility and legitimacy in the eyes of the consumer community
  - b. Reflect a real commitment by the Royal Commission to redress power imbalances that lead to abuse of our members
  - c. Enable the Systemic Consumer Advocate or Commissioner to be uncompromising in its advocacy, such as VMIAC has done, while enjoying the necessary institutional powers to gain information and generate accountability from government, and
  - d. Reflect the greater interest that consumers have in radical reform to the mental health system.
126. In a system saturated in entrenched power, consumers are constantly forced to make a Faustian Bargain. On the one hand, they may sit “inside the tent”, with the necessary legal machinery and power, but be compromised by contrary clinical, carer and bureaucratic objectives, and in so doing lose the faith of their own community. On the other hand, they choose independence “outside the tent”, maintaining their integrity, as well as their irrelevance. If the Royal Commission chooses to provide consumer leadership and advocacy at the systemic level, there is an opportunity to do this differently by providing consumers the resources and independence to make real change.
127. However, consumer leadership and participation must be core to all regulatory and oversight processes, including:
- a. Accreditation processes
  - b. Complaints management processes (within services and regulators)
  - c. Internal service quality improvement measures
  - d. Investigations into services and for sentinel events as experts, and
  - e. Inspection regimes.

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19< <https://www.apr.ch/en/resources/publications/monitoring-psychiatric-institutions-outcome-report-2016-jean-jacques-gautier?cat=62>>

<sup>79</sup> Jem Stevens, '3 Stevens, Jem, Institutional culture in detention: a framework for preventive monitoring, Penal Reform International and the Association for the Prevention of Torture (2015) 19.

128. This reflects emerging best-practice in monitoring and oversight,<sup>80</sup> as occurring in New Zealand, Scotland, Canada, and the United Kingdom.<sup>81</sup> The Australian Human Rights Commission has also signalled the importance of lived experience in future monitoring regimes.<sup>82</sup>

### Recommendation

Prioritise consumer leadership at all levels, functions, and activities of the regulatory and oversight processes.

### Designing for strong leadership

129. Consumers have consistently highlighted the gap between law and actual practice within the mental health system.<sup>83</sup> This is in part the result of failed regulation and oversight. While there are structural and policy elements explaining this, the role of leadership is equally important.
130. If key issues such as leadership are not adequately diagnosed, the recommendations relating to structural changes will not take foot in a new system.<sup>84</sup> It will also lead to a loss of confidence in the legitimacy of future leaders as holding the correct values in vision.<sup>85</sup>
131. Future structures or institutions that emerge from the Royal Commission will be impacted by the leaders who assume those roles. The types of leadership and relationships with mental health services need to be articulated clearly.
132. This may be addressed through recommendations or assertive commentary that clarify key statutory appointments should be:
  - a. Publicly advertised, to attract a strong and diverse range of candidates, and/or
  - b. Required by law undergo a nomination process from a relevant group, which can include consumer leaders.<sup>86</sup>

<sup>80</sup> Steven Caruana, 'Enhancing best practice inspection methodologies for oversight bodies with an Optional Protocol to the Convention against Torture Focus: Report to the Winston Churchill Memorial Trust of Australia' (*The Winston Churchill Memorial Trust*, 2018); National Aboriginal and Torres Strait Islander Legal Services, Submission No 47 to Australian Human Rights Commission, (*OPCAT in Australia Consultation*, July 2017), 18; Association for the Prevention of Torture, Submission No 26 to Australian Human Rights Commission, (*OPCAT in Australia Consultation*, July 2017), 8.

<sup>81</sup> Andreea Lachsz, Culturally appropriate oversight of conditions of detention and treatment of detained Aboriginal and Torres Strait Islander people in the Northern Territory's criminal justice system – in compliance with the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (2019) 21, available at <https://www.churchilltrust.com.au/project/?id=PR0014391>

<sup>82</sup> Australian Human Rights Commission, Implementing OPCAT in Australia (29 June 2020), 38 <  
<https://humanrights.gov.au/our-work/rights-and-freedoms/publications/implementing-opcat-australia-2020#:~:text=On%2021%20December%202017%2C%20the.it%20will%20comply%20with%20it.&text=Some%20progress%20in%20implementing%20OPCAT%20has%20been%20made%20since%20ratification>>

<sup>83</sup> Dr Christopher Maylea, 'Witness Statement 31 March 2020 to the Royal Commission into Victoria's Mental Health System' (2020) [23]

<sup>84</sup> As Windholz 'a diagnosis failure leads to a design failure which, in turn, leads to an implementation failure, and, collectively, all three can lead to a failure of public governance with the potential to undermine "the credibility of government and governance under the rule of law": Eric Windholz, *Governing through regulation: Public policy, regulation and the law* (Taylor & Francis 2017), 107.

<sup>85</sup> For example, Suchman highlights the importance communities place on personal qualities of "moral entrepreneurship" play in dismantling old institutions: Mark Suchman, 'Managing legitimacy: Strategic and institutional approaches' (1995) *Academy of management review* 20(3) 571-610, 581-582.

<sup>86</sup> These are drawn from examples provided by the Department of Premier and Cabinet, *Appointment and Remuneration Guidelines: Remuneration schedules effective from 1 July 2020* (Victorian Government, 2020), 5.23-5.25.

### Recommendation

Ensure that the final report includes assertive commentary on the leadership expected from key oversight bodies.

Ensure recommendations for statutory appointments are public and involve consumer input.

Ensure consumers are supported to take non-designated leadership positions.

### Embed practical measures to drive compliance and quality improvement

133. VMIAC supports strong standards and enforcement of those standards by independent regulators. Therefore, any measures that improve independence of regulators and clarify the standards they expect, will improve the system going forward.
134. We do note, however, resistance that may emerge from services. VMIAC hears the following explanations provided by services for poor practice or resistance to human rights standards:
  - a. That they are underfunded
  - b. That regulators lack expertise to truly understand service challenges and processes
  - c. That the services' local context requires a more nuanced approach
135. VMIAC acknowledges these concerns, but remains sceptical that they explain the scale of human rights violations and poor practice.
136. We are, however, aware that “buy-in” from services will require a level of legitimacy so that services develop an internal motivation to comply with standards.<sup>87</sup>
137. A “set-and-forget” strategy, by setting standards and expecting services to comply, would be unlikely to work. Firstly, because it does not *engage* consumers, civil society, services, and regulators in shared goals. This will be critical to set a foundation for action, and to articulate clear roles and accountabilities through social engagements. Second, it does not particularise to the contexts of specific mental health services, by failing to explain *how* they can comply with these standards, which may lead to services resisting these standards.
138. VMIAC supports strong standards to comply with human rights. If these occurred, they would be long-overdue. Equally, we understand the significant gap between where services are now, and where human rights-based treatment requires them to be.
139. VMIAC notes that the following measures may assist:
  - a. **Human rights impact assessments** – asking services to examine the impact of their services on human rights, including rights under the Charter
  - b. **Action plans** – publicly available action plans, co-produced with consumers, that articulate how services plan to realise their human rights obligations in all aspects of their service delivery

<sup>87</sup> The importance of legitimacy for “regulatees” has been well-established: Eric Windholz, *Governing through regulation: Public policy, regulation and the law* (Taylor & Francis 2017), 112; Julia Black, ‘Constructing and contesting legitimacy and accountability in polycentric regulatory regimes’ (2008) *Regulation and governance* 2(2), 137-164; Kristina Murphy, Tom Tyler, & Amy Curtis, ‘Nurturing regulatory compliance: Is procedural justice effective when people question the legitimacy of the law?’ (2009) *Regulation and governance* 3(1), 1-26.

- c. **Auditing** – auditing and progress reports on these measures to drive continuous improvement and accountability.
  - d. **Regulatory oversight** – ensuring that an independent regulator has regard to these action plans when undertaking their regulatory activities with services, alongside the objective
140. Such an approaches have many benefits, if done correctly. Models such as this, co-produced with consumers, enable greater participation of consumers and civil society, by enabling our involvement in the construction of these key actions, but also in notifying the regulator of the need for enforcement. These could apply to:
- a. Consumer workforce participation and organisational readiness
  - b. Mental health principles (including principles supported decision-making and recovery), and
  - c. Elimination of compulsory treatment, seclusion, and restraint.
141. These action plans and audits also become localized to each service, be co-produced with consumers, with support from a body such as the Office of the Chief Psychiatrist or Office of the Chief Mental Health Nurse.

### Recommendations

Ensure that there are practical, transparent, and public measures, such as the use of localised and transparent action plans, to drive compliance with consumer workforce participation, mental health principles as well as the elimination of compulsory treatment, seclusion and restraint.