Submission on Victoria's strategy towards elimination of seclusion and restraint

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Introduction

Please accept my feedback on the discussion paper on the *Strategy towards the elimination of seclusion and restraint*. My feedback will be brief but will focus on the following areas:

- The necessity of a formal acknowledgement of harm by the Victorian Government to provide
- The importance of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter**) to both all relevant bodies, including Safer Care Victoria, the Mental Health and Wellbeing Commission and public mental health services, and
- The critical role that improved regulation will be play in achieving the strategies vision.

Before moving to these points, I want to congratulate Safer Care Victoria and the External Working Group on their work to date. The discussion paper clearly identifies the Royal Commission into Victoria's Mental Health System's (**Royal Commission**) direction, as well as the work underway to date. It clearly identifies what the Victorian Government identifies as in-scope and out-of-scope. These are difficult conversations with diverse perspectives. All need to be heard, however consumers and survivors with experiences of seclusion and restraint, authorised by the state, need to be prioritised.

I make this submission with the following experience in mind:

- Lived experience of mental distress and trauma and as a consumer workforce member, but not of restrictive practices (and therefore do not speak from this group)
- Working as a Community Consumer Advocate (Victorian Mental Illness Awareness Council, **VMIAC**) and Independent Advocate (Independent Mental Health Advocacy, **IMHA**), where I visited close to two-thirds of Victoria's public inpatient units
- Working as Senior Resolutions Officer and Advisory Council member at the Mental Health Complaints Commissioner
- Working as a Project Coordinator for the *Your story, your say* project (Victoria Legal Aid)[1] and as Senior Project Officer to co-produce self-advocacy resources (IMHA)
- Policy experience working with the Victorian Equal Opportunity and Human Rights Commission, the Royal Commission (as a consumer reviewer), Chair of the Human Rights and Ethics Subcommittee on the board of VMIAC
- Project Lead of the State Acknowledgement of Harm Project which provided the *Not Before Time: Lived Experience-Led Justice and Repair* report to government[2]
- Supervisor to consumer workforce members currently working in public mental health services, and
- Author of articles on regulatory oversight, compliance with mental health laws, restorative justice, the Charter, and consumer workforce rights.[3]

I make this submission with very limited time and capacity, and would be grateful to discuss it further with the relevant Victorian Government figures.

Looking back to go forward: acknowledging harm in Victoria's mental health system

Many mental health consumers and survivors, and families, carers and supporters have been harmed by Victoria's mental health system. The use of seclusion and restraint has left indelible marks on consumers and survivors, and on their communities.

In February 2023 I was fortunate to be part of a group that provided advice to the Victorian Government on how to formally acknowledge harm in Victoria's mental health system. This became the *Not Before Time: Lived Experience-Led Justice and Repair*. In the report we identified harms to consumers and survivors and to families, carers and supporters. We stressed the profound harm that restrictive practices have had, and continue to have, on Victorians caught in the public mental health system.

This harm remains unacknowledged and unresolved. While this discussion paper does identify the harm, consumers and survivors have not been given the forum to share these harms in a way that provides restorative justice for them. That is why it is crucial that the Victorian Government takes the brave step of establishing a Restorative Justice Process to hear the harms in Victoria's mental health system. Only when we surface these past, present and future harms, can we come together and prevent these harms from reoccurring. A formal Restorative Justice Process, followed by apologies that we set out in *Not Before Time*, will animate this strategy and providing the cohering cultural force to eliminate these practices from our mental health system.

We're still forgetting the Charter

In 2021 Dr Chris Maylea and I published *Keeping Human Rights in Mind*,[4] which outlined the existing obligations that the public authorities have to comply with the Charter. The Department of Health, Safer Care Victoria, the Mental Health and Wellbeing Commission, the Chief Psychiatrist and public mental health services are just some of the parties that have existing legal obligations to comply with the Charter. I have concerns that there is no evidence of engagement with the Charter in this discussion paper.

The Charter is valuable to this strategy in several respects. For consumers and survivors, it is useful because it creates legal obligations on public servants – in addition to the duties they have under the *Public Administration Act 2004* (Vic) to promote human rights – to *properly consider* and *comply* with human rights. 'Proper consideration' reflects a duty on public servants to consider the Charter at the start of policy design processes, such as this discussion paper. It requires that public servants *think* about human rights, and that they are able to *evidence* that they have thought about human rights. A failure to evidence consideration of human rights risks breaching the Charter. This is different to other legal obligations in the *Mental Health Act 2014* (Vic), which are more focused on the 'service delivery' end of the decision-making chain.

Thinking about the Charter and human rights early in the policy design process will provide several benefits. For example, it will:

- Assist the Victorian Government to prioritise those marginsalised, by requiring that people enjoy equal protection of the law and equal enjoyment of their human rights, as well as ensuring that cultural rights (including Aboriginal cultural rights) are built into policy design processes from the beginning
- Focus policies and strategies on outcomes by centring consumers and survivors – those most impacted and whom experience the greatest human rights restrictions – in decision-making
- Assist to you navigate complex and intersecting interests by keeping ensuring any restrictions on rights are justifiable.[5]

In this case, a Charter-based analysis can assist the Victorian Government to address the following issues in the discussion paper.

The discussion paper's 'Lived-experience led' principle appears to talk about consumers and families, carers and supporters, the workforce and even the local community, in having a shared interest and stake in eliminating restrictive practices. Consumers are those whose rights are limited through these practices, not the other stakeholders. Their human rights need to be kept clear in mind, and where other group's rights, such as the workforce are considered, they need to be balanced against the depth and breadth of human rights limitations on consumers. Equivocating these interests will inevitably lead to Charter breaches by both the Department and by public mental health services. Consumers should be leading this process as they are the ones impacted by it. While other aspects of the mental health reforms may place consumers and families, carers and supporters on similar standing with each other, it is not appropriate in this context.

The disproportionate rates of restrictive practices as they impact Aboriginal Victorians is not reflected in the discussion paper. There is a curious absence of the latest Seclusion Report from VMIAC in the references, which in collaboration with local Aboriginal health services queried whether structural racism had a role.[6] Proper consideration of Aboriginal cultural rights under

the Charter would go beyond embracing First Peoples' wisdom – which is undoubtedly of value – to re-affirming their legal right to cultural safe services.

The cohort specific responses would also be strengthened not as principled statements, but as legal duties. This would be reflective of both section 8 of the Charter as well as existing duties under the *Equal Opportunity Act 2010* (Vic).

As a matter of urgency Safer Care Victoria, the relevant branches and any of the working groups involved in the stewardship of this strategy should receive specialist training on the Charter. The strategy should be reviewed in light of this and there should be steps put in place to ensure the Charter is considered at all key decision-making points going forward. These are existing legal duties on public servants and the Victorian Government.

Progress will be glacial without substantial improvements to regulatory oversight

The discussion paper notes the Chief Psychiatrist (**OCP**) and the Mental Health and Wellbeing Commission (**MHWC**), but properly examine their role or utilise their powers. I will focus on the MHWC, while noting that I have written about the OCP and the improvements it could make elsewhere.[7]

In focusing on the MHWC, I am centring the importance of 'regulation' to achieve this strategy. Regulation is often thought of as a lawyer's project, or literally the 'regulations' that sit under various laws (such as the *Mental Health Regulations 2014*). This is far too narrow a view of regulation.

Regulation has many definitions that can each prove useful for this strategy. A broad definition of regulation describes it as an effort to 'steer the flow of events'.[8] A broader, possibly more workable, definition of regulation is:

> 'An intentional form of intervention by public sector actors in the economic and social activities of a target population with the aim of achieving a public policy objective or set of objectives. The intervention can be direct and/or indirect, the activities can be economic and/or non-economic and the regulate may be a public or private sector actor.'[9]

Therefore, for the purposes of this strategy, a public sector actor(s) would be intervening in the activities of public mental health services (the target population) through direct and indirect measures to eliminate restrictive practices. Several bodies would be engaged in this process of regulation of restrictive practices – including Regional Mental Health and Wellbeing Bodies, the Department of Health, the Chief Psychiatrist and possibly Safer Care Victoria – to greater and lesser, and more direct and indirect degrees.

Mental health services must comply with mental health laws and the Charter. We know on both, they often do not. This means less restrictive alternatives were available but were not explored. This means that in many cases, there would be a breach of both mental health laws and the Charter.[10] This is in part a failure of regulation.

Regulators – depending on their powers – can employ a range of strategies to meet their policy objective (eliminating seclusion and restraint). Freiberg[11] identifies several of these, including:

- Legal regulation, such as the steps prescribed in the *Mental Health Act 2014* (Vic) and the *Mental Health and Wellbeing Act 2022* (Vic).

However, this is the most obvious. Other regulatory tools include:

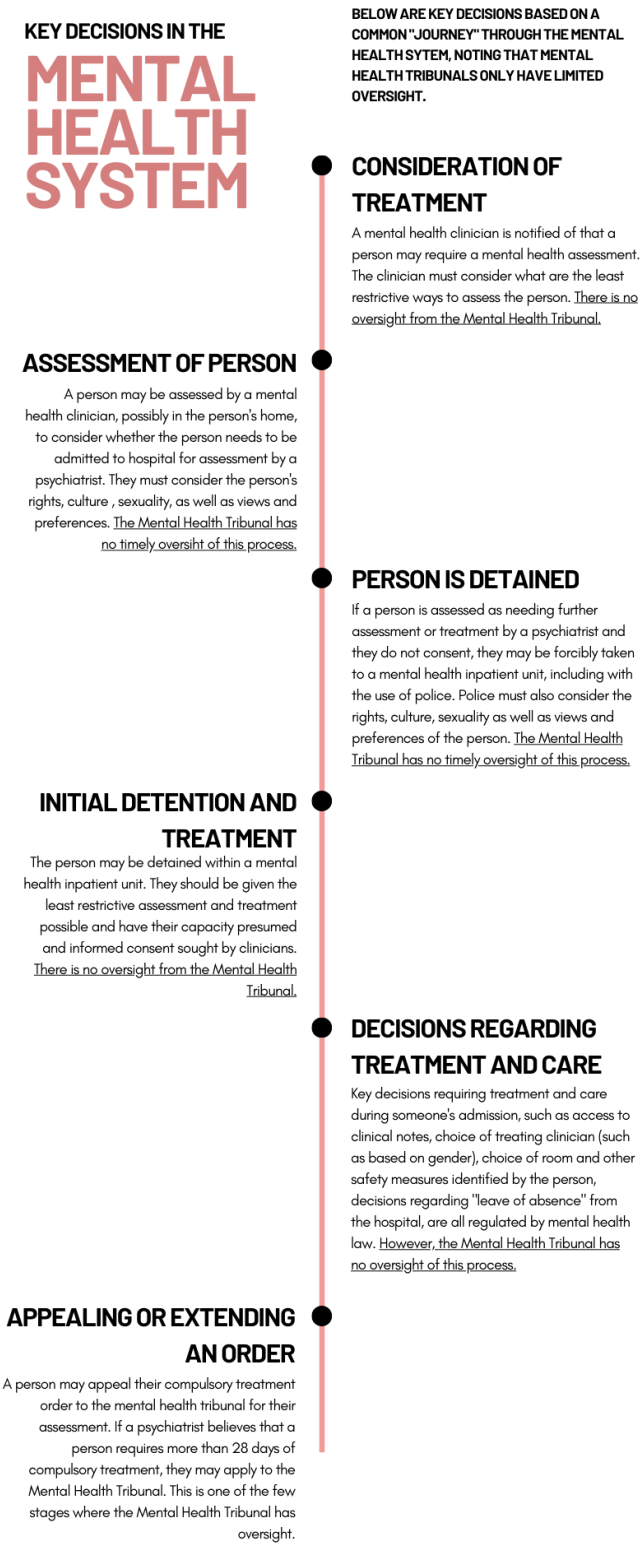
- Economic regulation (e.g. a carbon tax), which could consider the economic incentives that may incentivise vs disincentivise the use of seclusion and restraint
- Informational regulation, which will be met by the public reporting on seclusion and restraint rates to drive service-level and system-wide performance improvements, but also the provision of information to support capability development and promote excellent performance

- Contractual regulation, such as the use of commissioning standards refined and utilised by the Regional Boards to create specific duties on services to take steps to eliminating the use of seclusion and restraint
- Structural regulation, such as the addition (for instance independent authorisation steps to use restrictive practices from the Mental Health Tribunal after a period of time) of structures, or the removal of structures (including physical structures, such as the intentional reduction and elimination of the number of seclusion rooms available).

Many of these tools are available to the Chief Mental Health Officer, the Regional Bodies through the development of processes, standards, contractual obligations and more to meet this.

Legal regulation will require an enforcement body, and the MHWC will be central to this. The MHWC will have a central role, alongside these agencies, in doing so. The scope and reach of the MWHC's regulatory role is much broader than other bodies such as the Mental Health Tribunal. Whereas the Tribunal has oversight of a single decision-point in the legal chain, the MHWC has broad enforcement capability over any point of someone's engagement with a public mental health service. This is illustrated in the infographic on the right.

The legal regulation of closed environments is something that myself and Emeritus Professor Sharon Friel have written on in *Regulating rights: developing a human rights and mental health regulatory framework.*[12] I approached Professor Friel to collaborate on this because I believe that the current Mental Health Complaints Commission has failed to adequately regulate mental health services. If they had, there would be more evidence of the least restrictive practice possible, and greater reductions in the rates of compulsory treatment and restrictive practices. The size of the problem we face would be much smaller.



After a review of the relevant literature, we developed the Human Rights and Mental Health Regulatory Framework. It was squarely focused on the forthcoming MHWC and had seven key principles. These are detailed in full from an upcoming paper on the following page.

Table 1: Human Rights and Mental Health Regulatory Framework	
Principle	**Explanation / indicators**
Clear objectives	Establishment and articulation of clear regulatory objectives for promoting and protecting human rights. Indicators include: • Statutory objectives that clearly state a focus on protecting and promoting human rights • Public evidence of how the regulatory process has a rational connection to promoting and protecting human rights • Communications strategies and activities that indicate statutory objectives of promoting and protecting human rights.
Be responsive	Respond to mental health service's circumstances and level of motivation to respect and comply with human rights. Indicators include: • An understanding of the characteristics, capacities and motivations of each mental health service • Use of a diverse set of regulatory methods to achieve the regulatory goal of rights protection and promotion • A framework for promoting good practice, supporting capacity building and deterring wilful non-compliance.
Regulate risk	Allocate resources and regulatory interventions to actors or system components that pose a significant risk to human rights. Indicators include: • A framework for identifying where risks to human rights are greatest • Tools to monitor those risks through existing complaints and other regulatory processes • A strategy to apportion resources to system components and specific mental health services that pose greatest risk to mental health consumers' human rights.
Effective standards	Set a mix of prescriptive and outcome-focused standards to measure compliance with human rights. Indicators include: • Published practice guidelines or frameworks that articulate standards • The use of outcomes focused or principle-based standards and prescriptive standards based on the flexibility and certainty needed • Standards that indicate how the regulator makes decisions regarding its use of powers.
Judicious enforcement	Ensure the deliberate, transparent and robust use of enforcement measures. Indicators include: • Evidence of deliberate and considered use of education and capability-focused regulatory strategies • Evidence that the regulator monitors implementation or the effectiveness of recommendations or education and capability-development regulatory strategies • Evidence of the use of more coercive regulatory measures, such as investigations, enforceable undertakings and compliance notices, where less interventionist regulatory strategies have proved ineffective.
Tripartism	Engage third parties in the regulatory process, including people with lived experience. Indicators include: • Publishing of routine regulatory and complaints information that enables monitoring by civil society organisations • Recruitment of civil society organisations, including lived experience organisations, to assist with investigations and provide resolutions advice • Routine coordination with other regulatory organisations to achieve statutory objectives.
Balance power	Take positive steps to identify, name and address power-imbalances between complainants, mental health services and the regulator as part of the regulatory process and as an outcome of the regulatory process. Indicators include: • A framework for how the regulator understands, identifies and responds to the different types, forms and spaces where power operates in the regulatory process • Measures of change at the systems level, regulatory process and the service-provision level changes in power relations • Evidence that the regulator has people in leadership roles with lived experience.

In our review of the publicly available information, including that obtained under Freedom of Information, we found that the current Mental Health Complaints Commissioner was lacking in several of these areas. The current oversight document released by the Mental Health Complaints Commission still appears to lack an understanding that it has to use individual complaints in order to achieve broader regulatory goals, such as compliance with the *Mental Health Act 2014* (Vic), or in this case, the elimination of restrictive practices. It appears to still see it's role in a narrow dispute resolution function, which self-constraints its ability to utilise its cultural and legal powers to better protect human rights.

This strategy must have a deeper dialogue on these points than is available in this time-limited submission. That dialogue must engage current and forthcoming Commissioners in an awareness that their individual complaints must be 'never again' opportunities such that the a complaint cannot be closed unless the MHWC is confident that the conditions (that are within the control of the mental health service) that led to the use of that seclusion or restraint episode, are addressed. Importantly, there must enforcement of human rights to signal to the sector that they are a priority going forward.

The MHWC and credible enforcement alone is not sufficient. Capability development and resourcing remain important. However, we are nine years into the current Mental Health Complaints Commission, with 14 000 complaints and no compliance notices, while satisfaction for the body is dropping rapidly. This is the area of failure that has enabled the ongoing operation of a rights-breaching system. Conversely, it is also the area where we can be most hopeful of change. Improved regulatory performance would have an immediate change on the ground, and could substantially reduce the rates and duration of these practices. If this is improved, we will revisit this conversation with regret.

[1] 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) <https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-your-story-your-say-report.pdf>.
[2] Simon Katterl, et al, *Not before Time: Lived Experience-Led Justice and Repair (Advice to the Victorian Mental Health Minister)* (January 2023).
[3] Simon Katterl, 'Regulatory Oversight, Mental Health and Human Rights' (2021) 46(2) *Alternative Law Journal* 149; Simon Katterl, 'The Importance of Motivational Postures to Mental Health Regulators: Lessons for Victoria's Mental Health System in Reducing the Use of Force' [2021] *Australasian Psychiatry* 10398562211038912; Simon Katterl, 'Examining the Workplace Rights of Mental Health Consumer Workers' (2022) Advanced online publication *Australian Health Review*; Simon Katterl, 'Preventing and Responding to Harm: Restorative and Responsive Regulation in Victoria, Australia' (2022) Early View *Journal of Social Issues*; Simon Katterl, 'Words That Hurt: Why Mental Health Stigma Is Often Vilification, and Requires Legal Protection' (2023) 0(0) *Alternative Law Journal* 1; Simon Katterl and Sharon Friel, 'Developing a Human Rights and Mental Health Regulatory Framework for Victoria, Australia' Forthcoming *Australian Journal of Human Rights*; Simon Katterl and Chris Maylea, 'Keeping Human Rights in Mind: Embedding the Victorian Charter of Human Rights into the Public Mental Health System' (2021) 27(1) *Australian Journal of Human Rights* 58; Chris Maylea et al, 'Consumers' Experiences of Rights-Based Mental Health Laws: Lessons from Victoria, Australia' (2021) 78 *International Journal of Law and Psychiatry* <https://doi.org/10.1016/j.ijlp.2021.101737.>.
[4] Katterl and Maylea (n 3).
[5] This is drawn from forthcoming advice: Simon Katterl and Kerin Leonard, 'Putting human rights at the heart: Thinking about human rights (Guide for the Mental Health and Wellbeing Division)' (forthcoming, 2023).
[6] Victorian Mental Illness Awareness Council, *Seclusion Report # 3* (Victorian Mental Illness Awareness Council, 2022) <https://www.vmiac.org.au/wp-content/uploads/VMIAC-Seclusion-Report-3_2020-21_Web-Version-2.2_300dpi-High-res-1.pdf>.
[7] Katterl, 'Regulatory Oversight, Mental Health and Human Rights' (n 3).
[8] John Braithwaite and Christine Parker, 'Regulation' in Peter Cane and Mark V Tushnet (eds), *The Oxford Handbook of Legal Studies* (Oxford University Press, 2003).
[9] Arie Freiberg, *Regulation in Australia* (Federation Press, 2017).
[10] Jonathan Knott et al, 'Restrictive Interventions in Victorian Emergency Departments: A Study of Current Clinical Practice' (2020) 32(3) *Emergency Medicine Australasia* 393; Katterl and Maylea (n 3); Katterl, 'Regulatory Oversight, Mental Health and Human Rights' (n 3); Maylea et al (n 3).
[11] Freiberg (n 9).
[12] {Citation}