CoMHWA

Consumers of Mental Health WA (Inc)

Submission to the

Senate Community Affairs References Committee

for the

Inquiry into Violence, abuse and neglect against people with disability in institutional and residential settings

By Consumers of Mental Health WA (Inc)

Submitted 29th June 2015

About the Consultation Respondents

Consumers* of Mental Health WA (CoMHWA) is a systemic advocacy organization run for and by consumers in Western Australia, whose core purpose is to listen, understand and act upon the voice of consumers in mental health services and the wider community.

We do so through member consultation and information services, systemic advocacy and representation, collaborative partnerships and relationships, education, training and awareness raising.

We are currently a small organization with 395 individual and organizational members, but well respected and supported for our comprehensive and informed perspectives on consumer inclusion and empowerment, peer led approaches, and recovery and wellbeing.

***Consumer:** a person who identifies as having a current or past lived experience of psychological or emotional distress, issues, or problems, irrespective of whether they have a diagnosed mental illness and/or have received treatment; or a person who identifies as a mental health consumer and has been, or is, a consumer of mental health services

CoMHWA

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Note

CoMHWA advises readers that some of the reports we have received, which have been documented in this submission, may be distressing.

The following resources may be of support if you have been affected by violence, abuse or neglect:

- Lifeline offers 24 hour crisis support and suicide prevention services – phone 13 11 14.
- Should you be experiencing institutional violence, abuse or neglect and would like to talk to someone, or suspect abuse and neglect, please contact the National Disability Abuse Hotline on 1800 880 052.
- For information on advocacy services, you are welcome to contact CoMHWA on (08) 9321 4994 or please visit our website at: http://www.comhwa.org.au/getting-help/

Executive Summary

CoMHWA welcomes the opportunity to share our concern with the Committee about serious rights issues of institutional violence, abuse and neglect, and to bring consumers' voices to the process.

Our public submission describes the largely grassroots but concerning reports of violence, abuse and neglect which CoMHWA has received in our work as a systemic advocacy organisation for and by consumers. CoMHWA has also collated testimonies from people who identify as survivors of institutional violence, abuse and neglect which have been submitted in a second, private submission.

CoMHWA presents a number of recommendations for improving prevention and responses, including support for a Zero Tolerance of Violence culture and framework, strengthening of UNCRPD commitment, adherence and reporting by mental health services, and a mental health system that mainstreams trauma-free design, trauma-informed care and practice, and trauma-focused supports.

Our chief recommendation is that a Royal Commission to be held in relation to institutional violence, abuse and neglect on the basis that:

1. The extent and prevalence of the issue will not be fully understood without a structured, supportive, extensive and genuinely independent process for survivors to come forwards with their testimonies, independent of mental health services and with clarity and confidence that their testimonies will be heard, believed and adequately addressed. This is primarily due to the fragmented nature and limited effectiveness of existing complaints and oversight systems that produce clear barriers and disincentives to disclosure, and thus an inaccurate picture of the violence that is endured;
2. The distance and isolation of formal submission processes from those most vulnerable to abuse and neglect due to their institutionalisation requires an extended process in which governments and agencies work together to identify and support survivors to come forwards,
3. Such a process for survivors does not currently exist;
4. Until such testimonies are gathered, there is also insufficient knowledge of practical steps mental health consumers put forward, based on their lived experience of faults in the system, to make concrete recommendations that will improve community understanding, reporting on and prevention of institutional abuse and neglect.
5. Supporting whistleblowers and past and present witnesses is important in the process of collecting evidence, which a parliamentary Inquiry cannot facilitate in and of itself.

CoMHWA cautions that there are unique obligations and challenges presented by any Royal Commission in relation to institutional violence in mental health residential settings and institutions:

6. The situation of mental health consumers in relation to this federal inquiry is unique because of mental health legislation. Specific governmental laws apply to them that authorise practitioners to detain, seclude, restrain and to administer treatments without their consent.

When mental health issues are viewed as a specific type of disability under the UNCPD, our society must be willing and open to debating the morality of discriminatory legal approaches for specific classes of people with disability, as opposed to universal approaches to situations for supporting decision-making capacity and mechanisms to prevent harm and support wellbeing where capacity is diminished.

7. Consumers would seek to bring before a Royal Commission both lawful and unlawful cases of violence, abuse and neglect that have caused personal harm and are morally objectionable.
8. There are significant stakes involved, and system inertia, that present barriers to a truly independent, rigorous re-thinking of our fundamental attitudes to the human rights to freedom, dignity and health of people affected by mental health issues.

1. Mental Health Consumers' Experience of Violence, Neglect and Abuse in Residential and Institutional Settings

CoMHWA has collated testimonies from people who identify as survivors of institutional violence, abuse and neglect. These have been submitted in a second, private submission. 5 testimonies with received, with a further 3 people who enquired but did not provide a submission within the time frame of the Inquiry.

The number of submissions should not be taken as indicative of prevalence of the issue, because there are significant and varied barriers to survivors coming forwards. The barriers to disclosure are further discussed at *3. Incidence and Prevalence*.

Abuse, neglect and violence for mental health consumers have a strong contextual dimension (i.e. the specificities of mental health legislation and institutional settings) that need to be taken into account, particularly in understanding how consumers' interpret and experience these issues.

The prominent ways in which abuse, neglect and violence are patterned for mental health consumers, via their interaction with mental health services.

Stigma, Discrimination and Violence

Consumers' frequently experience services and supports that are inconsistent with UNCRPD Principles of:

- "Non-Discrimination" and
- "Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".

Mental health stigma, in which people with mental health issues are viewed in terms of their deficits and incapacities- not their potentiality, value and strengths, is widespread. Mental health stigma is also widespread in mental health professionals and services, resulting in discrimination compared to general health patients in norms of decision-making and consent. This can lead to rights shortfalls in areas of privacy & confidentiality; informed consent to treatment; and freedom to make decisions about their lives.

Because of its widespread nature, mental health stigma and accompanying discrimination are forms of structural violence – types of violence that are ongoing and patterned towards certain groups and whose explanation lies in the social organisation and tolerance of violence[1]. As a type of structural

[1] Mayton, D.M. II. 2009. Non-Violence and Peace Psychology, London, UK: Springer, p.4

violence, mental health stigma and discrimination increase the likelihood of violence, abuse and neglect in institutional settings and they present a major barrier to the establishment of effective institutional responses.

CoMHWA presents the following concerns as non-exhaustive, but illustrative of, the sorts of institutional violence that consumers face. These have been compiled based on ongoing contact with members and other consumers and families. In the absence of wide concern and adequate systems, institutional violence largely emerges via word-of-mouth and anecdotal reports.

(i) Lawful Acts of Violence: Authorised use of physical force or power under the Mental Health Act, where violence is legally permitted but morally abhorrent in direct experience. This includes involuntary detention; involuntary treatment; and 'restrictive practices'. Restrictive practices include restraint (mechanical, bodily and chemical) and seclusion (being placed along in a room from which one cannot exit, and which may include the removal of clothing and the withholding of bedding, food, water and toileting).

(ii) Abuse or Assault by Staff: Where physical or sexual assault, verbal or emotional abuse by staff has occurred. Several anecdotal reports of undue use of force by police in transport of persons to mental health services have been reported. CoMHWA has been advised of a psychiatric ward in Western Australia being referred to by staff as the 'nut farm', and consumers have reported numerous staff at different sites using the term 'frequent flyers' as a signal of contempt towards consumers who need to access support on multiple occasions.

(iii) Safety Issues Between Consumers in Institutional Environments: Safety with respect to other people within ward environments may be compromised, leading to physical or sexual assaults, verbal or emotional abuse by consumers within the environment. This issue has been reported as particularly significant in mixed sex-wards and hostels, in shared dorms or patient bedrooms that do not have locks, and where generally there are lack of resources to manage the risk to other patients of violent or aggressive patients.

(iv) Cultures of Coercion and Control: Cultures of coercion and control by mental health professionals that substantively limit personal choice and control. A common example is the 'Voluntary Involuntary Patient", in which a clinician presents a person with an option of complying with their decision and remaining 'voluntary', or being made involuntary for not complying. Such clinicians thus use subjugation (compliance), rather than an objective assessment of whether the person can decide. Frequently an advocate is not present as the person is voluntary, thus not eligible for statutory advocacy. One stakeholder mentioned a service that assigns a list of voluntary persons who are not free to leave to security personnel.

(v) Crisis-Oriented Care and Involuntary Approaches: Our mental health services are not adequate to meet needs and focus on providing treatment and support to people when they

hit a crisis point. When people are not supported until they are in crisis, they are more likely to experience involuntary (coerced) care with rights curtailments. Thus, there is a direct link between shortages in mental health supports and the likelihood people will experience institutional violence.

(vi) Neglect and Preventable Suicide: An issue of great concern to consumers and families is the failure of services to provide urgent and appropriate care in times of crisis and the attempted and completed suicides that result from being turned away in times of crisis. This leaves an enormous burden of grief and trauma for survivors of suicide attempts and the families of people who have suicided.

(vii) Prescription Medications and Premature Death: Consumers have different experiences of medication – some experience this as vital and helpful, others as unhelpful or seriously harmful. Medications can carry risks of serious adverse effects either through adverse reactions or long-term use, leading to permanent disability, morbidity and premature mortality. Consequently, responsible prescribing and informed consent to treatment are important to reducing the risks of morbidity, disease and mortality associated with medication. Consumers are reporting shortfalls in responsible prescribing and informed consent, including:

- Serious incidents in administration or a drug or treatment, such as administration of drugs to patients despite noted allergy;
- Prolonged treatment where there are known risks to prolonged use, such as cardiac failure;
- Medication used as an involuntary treatment approach (i.e. medication against or without the person's consent);
- Off-label prescribing and failure to inform patients on the lack of long term safety data for newer medications;
- Lack of adequate informed consent processes, such as due to lack of time with the provider to explain medication benefits and risks;
- Lack of knowledge of the long-term effects of polypharmacy interactions (where multiple psychotropic medications are used simultaneously)
- Use of force in medications administrations causing muscular or nerve injury (e.g. forcible depots)
- Falls injuries associated with high levels of sedation
- Incapacitating the person through high levels of sedation, with consequent risks of abuse and neglect

Consumers are reporting polypharmacy as an issue in public mental health services and reported and the use of medication as the primary and mainstay of treatment (rather than as an element to be considered alongside psychological therapies and self-management approaches) by GPs and public mental health services. Prevailing attitudes surrounding some

diagnoses, such as bipolar and schizophrenia, are that recovery is not possible and life-long medication is required. These groups are those that carry the lowest physical outcomes, with a life expectancy up to 20 years less than people without mental illness.

(viii) Re-traumatisation as a result of provision of non-trauma-informed services: There are high rates of trauma history among people accessing mental health services. Services and staff that are not effective at identifying and supporting people who have experienced trauma may re-traumatise individuals, as is illustrated by the testimonies submitted.

(ix) Complaints System Failures: Consumers are also reporting low satisfaction with complaints mechanisms, particularly in terms of lack of outcomes and penalties for services and not being supported by staff when they report concerns for their safety.

(x) Criminalisation of Consumers: Mental health emergencies are sometimes managed by police where police do not need to be involved, simply due to lack of specially equipped services and response mechanisms. For example, police – not ambulance or mental health personnel- are called by default in a mental health emergency if the person is not on the clinical records system of the emergency mental health service. Police involvement can be shocking, confronting and humiliating for people because they can feel their distress has been criminalised.

2. The Impact of Institutional Violence on Mental Health Consumers' Lives

Neglect and Suicide

In 2010, a Senate Inquiry, the *Hidden Toll: Suicide in Australia,* was conducted. The *Hidden Toll* report stated that

> "the personal and social impacts of suicide and attempted suicide on those affected…are clearly enormous. No matter what the economic cost of suicide is calculated to be, a moral or human obligation exists to assist those at risk of suicide and those who have been bereaved by suicide"[2].

Suicide is a major issue in our society. It is estimated 90% of people who suicide have a mental illness diagnosis, and that rates of suicide are 5- 15 times than in the general population[3].Despite these statistics, mental health consumers are rarely an explicit focus of suicide prevention strategies.

Where suicide occurs as a result of failure to provide care, or harmful care, then the loss of life is death by institutional neglect. Ascertaining the extent to which this occurs is difficult- it requires a shared set of standards of care in responding to people at risk, and requires significant and well-designed coronial investigation processes in order to understand the relationship between the service conduct and other factors. However, there has been media coverage in the past year where people have suicided soon after being denied emergency mental health care. CoMHWA received reports of 6 separate individuals completing suicide over a 6 month period who presented to emergency departments or mental health clinics for emergency mental health care but were turned away, in addition to 4 media reports (2 in WA) of persons completing suicide after being turned away from services (1 suicide, plus the homicide of a family member). In the UK, a review of deaths found 43% of mental health consumers who suicided had attended an emergency department, and 91% had seen GPs, in the weeks prior to their suicide[4]. Given these high rates of contact with health professionals prior to suicide, and the recent insights that bereaved families have provided into the challenges of accessing emergency mental health care, suicides related to institutional neglect are of key concern and need to be further investigated.

Other Impacts of Institutional Violence, Abuse and Neglect

[2] As quoted in Suicide Prevention Australia. 2014. *Work and Suicide Prevention*, p.6, http://suicidepreventionaust.org/wp-content/uploads/2014/02/Work-and-Suicide-Prevention-FINAL.pdf

[3] Windfuhr, K. and N. Kapur. 2011. Suicide and Mental Illness: A Clinical Review of 15 Years Finings from the UK National Confidential Inquiry into Suicide. *British Medical Bulletin.* 100(1):101-121. *doi: 10.1093/bmb/ldr042*

[4] Ibid

Consumers have reported to CoMHWA impacts that include:

- Trauma, including post-traumatic stress disorder. The effects of trauma include difficulties with sleep, chronic anxiety, unwanted and distressing memories, relationship difficulties and physical issues such as fibromyalgia, chronic pain and fatigue;
- Chronic disease and mortality associated with poor physical health care and medication side-effects
- Grief and loss arising from peers and family members who have taken their lives, died or otherwise been harmed;
- Intergenerational trauma;
- Self-esteem and self-worth issues associated with stigma and discrimination;
- Chronic disease resulting from injury from assault, restraint or forced treatments;
- Stress associated with poor complaints systems responses;
- Family breakdown, such as a result of failure to provide adequate mental health care and support when mental health needs are having impacts on the family, and exclusion of family members from care involvement

Historical Issues, Inter-Generational Trauma and the Consumer Movement

In 2014 CoMHWA contributed to a highly successful advocacy campaign *Shut Bethlam Down,* which called upon the closure of a show attraction themed as an insane asylum. CoMHWA received personal comments from several members who shared memories of their parents or grandparents mental health institutional treatment. For some mental health consumers, their survivor testimonies are also as witnesses to intergenerational experiences of institutionalisation, including service neglect of the children of people taken into mental health institutions.

While large-scale institutions that completely segregate consumers from society in physical isolation (the traditional asylums) are being progressively abolished, today's institutional settings (psychiatric hospitals and hostels or halfway houses) still share continuity in terms of physical and institutional isolation, restriction of freedoms, and risks of coercion and violence. Because of this, intergenerational trauma impacts do not just refer to the ongoing effects of historical trauma events on subsequent generations, but also to persons who are currently experiencing trauma related to their own institutional that bears similarities to family member experiences.

3. Incidence and Prevalence of Violence, Abuse and Neglect

The incidence and prevalence of violence, abuse and neglect cannot be accurately measured in Australia from existing data sources. Issues with data reporting are discussed later, and barriers to disclosure are discussed below.

Factors that are likely to be contributing to lack of data include: barriers to disclosure; lack of public transparency in data collection processes (i.e. agency reports not published); lack of mandatory reporting of many types of violence within mental health services; and lack of overarching processes for consumers to specifically come forwards and report mental health institutional violence, abuse and neglect.

A U.S. study of 142 consumers randomly selected from a mental health service found that mental health consumers self-reported:

- Physical assault on one or more occasions (31%)
- Witnessing traumatic events (63%)
- Sexual assault on one or more occasions (8%)
- Seclusion on one or more occasions (59%)
- Restraint on one or more occasions (34%)
- Being pushed down onto the ground by staff members ('takedowns') (29%)
- Being handcuffed during transport (65%)[5]

These experiences occur in a context where it has been established that consumers had high rates of prior victimisation (51 to 98%) and of posttraumatic stress disorder (up to 43%)[6]. The frequency of exposure to violence in settings hat are aimed to be therapeutic for the people they serve (who have already been adversely affected by violence, in the majority of cases) is appalling. It has also been established that sexual abuse in childhood and adolescence increases the risk of re-victimisation in adulthood- that is, that services are working with people whose risks of becoming victims of violence are higher than those of the average population[7].

Historic, Lawful Violence and Abuse

[5] Frueh, C. et al. 2005. Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences within the Psychiatric Setting. 56(9):1123-1133, p. 1123. http://www.peerzone.info/sites/default/files/resources/Frueh%20Patient%27s%20Reports%20of%20Traumatic%20Experiences%20in%20Psychiatric%20Settings.pdf

[6] ibid

[7] Bebbington et al. 2011. Child Sexual Abuse Reported by an English National Sample: Characteristics and Demography. *Soc Psychiatry Psychiatr Epidemiol.* 46:255-262; see also. Stahopoulos, M. 2014. *Research Summary- Sexual Revictimisation: Individual, Interpersonal and Contextual Factors.* Australian Centre for the Study of Sexual Assault.

Mental Health Legislation has evolved through the 20th and 21st centuries. Contemporary legislation still presents rights shortfalls, but there are some practices that are condemned and unlawful today which older survivors may have been subjected to or witnessed. This includes involuntary sterilisation, psycho-surgery (e.g. lobotomy), deep sleep therapies, cold water treatments, chemical convulsive therapy, insulin coma therapy, caging, straitjacketing, long-duration seclusion and restraint and hallucinogen administration. Such treatments were risky and experimental, causing death, injury and/or permanent disability, as well as constituting gross and inhumane acts that, in violating dignity and bodily integrity, are serious rights abuses. There has been little to no recognition, remembrance or apology to victims, other than among peer survivors and asylum historians.

Barriers to Disclosure

CoMWHA received 5 testimonies and valued the extended time frame as some testimonies were received in the later part of the submission period.

Disclosing a personal account of violence, abuse and neglect is often a distressing and difficult journey if healing and recovery-focused approaches are not well embedded in the institutional processes for disclosure.

Whether people choose to disclose incidence of violence, abuse and neglect depends on many factors, such as:

- Having an understanding of violence, abuse and neglect; or advocates and supports who have this understanding and with whom they are likely to disclose things that concern them in order to identify rights concerns;
- Knowledge of how to report, who to report to, and the consequences of reporting, through which to make an informed decision to disclose. This includes understanding whether there will be any risk of further harm as a result of disclosing , such as reprisal or being disadvantaged for future services;
- Confidence that their views will be heard and that their experiences will be validated- not disregarded. Consumers have often had negative experiences of complaints processes as:
    - Difficult to understand and navigate
    - Focus on processing the issue, rather than the importance of interpersonal relationships in resolution;
    - Do not provide adequate encouragement and support
    - Do not adequately protect victims from risks of further victimisation
    - Do not provide robust, independent investigation
    - Do not provide for sufficient remedy and are unlikely to be resolved in the victim's favour

- Whether there are adequate supports offered to address the potential emotional consequences of disclosure (such as the exacerbation of trauma);
- Whether they will be adequately supported in justice and healing once they disclose, such as through being protected from further harm, compensation, counselling, and action taken against perpetrators;
- Whether processes are designed to be just, offering a fair and supportive hearing;
- The extent of control they will have over the process (victim-centred approaches), from disclosure to outcome, including flexible time frames across each stage of the process;
- Person-centred and tailored approaches that accommodate people's needs and circumstances, such as people who are currently detained in mental health hospitals. Of the 5 testimonies received, 4 people used peer support options such as typing assistance, one-to-one meetings, and advice on the process.

Barriers to consumer reporting for this Inquiry included:

- Consumers commonly do not know where to go and generally report complaints processes as failing to meet their needs. This context is not sufficiently safe and just to promote self-reporting of institutional violence.
- Limited awareness of the Inquiry among the mental health sector in terms of the Inquiry's scope including mental health- thus limited awareness of the Inquiry by mental health consumers;
- Limited reach due to time frame- it would not have been a suitable time frame for some people to come forwards;
- While the Inquiry was more accommodating than other parliamentary Inquiries to support people coming forwards, Inquiries by their nature are not able to provide comprehensive structures and processes addressing the above factors in disclosure
- Need for mental health targeted approaches: Sectoral distance of many mental health stakeholders from disability language and sector

4.Responses to Violence, Abuse and Neglect

Legal, Policy, Regulatory and Governance Frameworks

Mental Health Commissions are a relatively new approach in mental health, but have been established in most states and territories and at national level to provide overarching reform leadership of mental health systems. These show promise in increasing recognition of the voices, needs and priorities of mental health consumers – such as their desire for recovery-focused, person-centred and respectful supports. Additionally, the National Mental Health Commission has shown leadership in its work on Seclusion and Restraint, in partnership with Melbourne University, to raise multi-stakeholder commitment to work towards the elimination of seclusion and restraint practices.

At the same time, there is still insufficient commitment to human rights leadership in the mental health system, including leadership of broader community awareness and opposition to institutional violence, and capability for prevention and response to violence, abuse and neglect.

For example,

- Mental health legislation is specific to states and territories, which leads to uneven civil rights curtailments across different jurisdictions
- The UNCRPD does not seem widely known or discussed within the mental health sector as a guiding approach for orienting services and systems to mental health rights;
- Most mental health institutions and systems have a strong focus on complaints management which carry a risk of channelling cases of abuse, neglect or violence into routine administrative resolution processes. In part, the sheer volume of rights concerns by mental health consumers generated by violence and rights restrictions under the Mental Health Act - such as deprivation of liberty, involuntary treatment, seclusion and restraint- encourages a routinized and at times tokenistic approach to human rights matters that have severe impact on people's lives. Such approaches do not offer justice and healing to survivors.
- The mental health sector has a strong reliance on quality standards as the primary safeguarding mechanism in the mental health sector (the National Mental Health Standards and the Australian Safety, Health and Quality Standards).
- While the National Standards include provisions for Safety, there is a lack of specific resources, training and overarching frameworks for violence, abuse and neglect of mental health consumers that would be equivalent to the NDS Zero Tolerance Framework.

Australia's compliance with international obligations

The thrust of the UNCRPD is to ensure that people with disabilities achieve substantive equality as citizens. As McSherry writes, "the Convention of the Rights of Persons with Disabilities is providing

the impetus for challenging the justifications for why we have mental health laws at all." [8] Mental Health legislation, which sets different human rights arrangements for mental health consumers relative to people with other disabilities and citizens without mental illness, erects a barrier to UNCRPD protections for mental health consumers. Part of the work of several state and territory Commissions have been to review and reform mental health legislation to focus on additional rights protections, such as advanced directives. However, the more fundamental rationale for a legislation which segregates rights frameworks for mental health consumers from analogous situations (duty of care issues in situations where decision-making capacity is at risk) has been subject to little debate or challenge in Australia.

Precisely because mental health legislation is specific legislation that targets involuntary care and treatment, there is limited general public awareness of the distinctive rights curtailments faced by mental health consumers. Few Australians are aware that a person in extreme distress- such as yelling and screaming- can be stripped of clothing, pinned to a mattress on the ground face down by multiple people, injected in the buttocks with tranquilisers, and monitored without clothing in a locked room on a surveillance camera for several hours, with no access to toilet facilities, as part of lawful health care activity.

Response to Disclosure

- In relation to the outcome of disclosure, CoMHWA has received reports from several consumers that they were actively discouraged, or not provided with support, to file police reports when they were assaulted by another consumer in a mental health setting. CoMHWA is also aware of 2 consumers who experienced gatekeeping of access to sexual assault counselling (assaults external to service delivery environment) by their clinical mental health providers, on account of a diagnosed or suspected psychosis or intellectual disability, resulting in failure to receive sexual assault counselling.
- Consumers do not have clear, concise, readily accessible guidance that would assist disclosure about institutional violence, neglect or abuse.
- While practitioner misconduct can result in Australian Health Practitioner Regulation Agency (APHRA) notification with suspension or termination of registration in certain malpractice cases, there are many workers within the mental health system that are not regulated by AHPRA (e.g. Social Workers and community mental health workers).
- Most states have notifiable incident reporting, which includes in WA via the Office of the Chief Psychiatrist, a requirement for clinicians to report to the Chief Psychiatrist serious assault, sexual assault and/or allegations of sexual assault and allegations of staff misconduct. These are focused on services meeting their obligations to refer serious incidents to overseeing

[8] McSherry, B. Time to rethink mental health laws for treatment without consent. 05/10/12. http://theconversation.com/time-to-rethink-mental-health-laws-for-treatment-without-consent-9302

bodies, but do not have any publicly documented supportive mechanisms for consumers to disclose incidents either to services or to directly disclose to the overseeing bodies.

- In Western Australia, Health and Disability Services Complaints Officer (HaDSCO) will only address mental health complaints if reasonable steps have been taken to resolve complaints with the mental health services. This presents a barrier for consumers reporting, who may continue to be receiving services from the provider, including as involuntary patients, and fear reprisal. HaDSCO cannot enforce a health service to cooperate with conciliation, mediation or investigation where the service refuses to engage. CoMHWA is also of the understanding that victim privacy cannot be upheld should HaDSCO need to report to APHRA, due to the requirement that APHRA be provided with patient details, which are then communicated to the health service in the course of APHRA's investigation. Consequently, there are several procedural barriers to consumers feeling safe to report serious matters to investigative bodies.

Whistleblowers

CoMHWA is unable to comment specifically on whistleblower issues. We note that at a public forum on WA protections, the absence of whistleblowing protection to protect stakeholders who are not government employees was raised as a barrier to the reporting and investigation of cases[9].

Advocacy- Role & Challenges

Advocacy in mental health settings is generally recognised by states and territories as essential as part of the mental health legislative framework with statutory, independent advocacy bodies (such as the Council of Official Visitors in Western Australia). However, there are a wide number of contexts relating to violence, abuse and neglect for which consumers may seek or benefit from advocacy, and which are beyond the scope of statutory, funded advocacy services. Examples include:

- People who identify as 'voluntary involuntary patients'- those coerced with threat of involuntary status to comply with detention and treatment. CoMHWA was advised by a family member of a consumer who was 'voluntary involuntary' for 8 months in a psychiatric facility, with no authorised leave and where leave sought to seek a second opinion from an independent psychiatrist was denied by the health service;
- People at risk of suicide who receive inadequate mental health assessments at emergency departments;
- People who fall through the gaps of services and are at increased risk of victimisation and exploitation in the community;
- People being victimised in their homes, such as via violence in public tenancies;

[9] WA Disability Abuse Forum, hosted by Development Disability WA, United Voice & People with Disabilities WA.

- CALD community members who may have additional advocacy needs in relation to culturally safe and appropriate services;
- People whose mental health diagnosis influences assessments about the safety of the child, and thus raises risks of child removal by child protection agencies;
- We have received two reports from members of the public concerned that the nominated carer/guardian is abusive and that their capacity to influence treating clinical teams formed part of the pattern of abuse and control (such as influencing decisions about admission or discharge and controlling access to advocates) In both cases, the consumers were male and Western Australia has no domestic violence services for male victims of domestic violence, nor domestic violence programs tailored to the needs of mental health consumers.

Statutory advocacy services have powers to access facilities and inspect documents, that non-statutory advocacy service and informal advocates do not. Despite statutory advocacy involvement, few consumers experience success in appeal processes to mental health tribunals.

Statutory advocacy services play vital roles but can only operate within their legal mandate. Non-statutory, community based advocacy services generally have greater flexibility to work across a broader range of advocacy issues and settings where violence, abuse and neglect is occurring or where individuals are at risk and which sit beyond the scope of statutory advocacy. Advocacy services are typically challenged by limited capacity to meet demand. Our understanding is that advocacy services need to make often difficult priorities about who to support, in the light of their limited capacity.

Advocacy services are a key resource for disclosure by victims and whistleblowers. CoMWHA recommends that any broad approach to improving abuse prevention and response should ensure that advocates (both statutory and non-statutory, formal and informal) are supported to have the procedural knowledge, training and relationships/partnerships that can support appropriate detection and response of violence, abuse and neglect. Consistent with disability safeguarding approaches, this should be holistic (focused on supporting safety across a range of relationships, not just services). Part of supporting advocates in these holistic approaches should include recognition of the need for advocacy partnership to share information, coordination and expert responses across settings where violence, abuse or neglect may occur.

Reporting and Data Collection

There is a need to consider the consistency and adequacy of notifiable incident reporting across different jurisdictions to support equality of reporting mechanisms across states and territories.

Most data captured in relation to institutional violence is not publicly available but must be sought through parliamentary questions or direct application to the agency for their statistical information. This includes statistics captured by the National Disability Abuse and Neglect Hotline[10].

Consumers may currently lodge complaints in WA with the services concerned, HaDSCO (after raising with the service concerned), the Chief Psychiatrist, the Mental Health Commission of WA, AHPRA, mental health, health consumer and disability advocacy organisations. Consumers also sometimes choose to raise complaints directly with ministers of parliament or go directly to the media.There is no shared data reporting system that would investigate and public report on the number of complaints successfully resolved, the types of complaints made, and reporting on incidents of violence, abuse or neglect raised within complaints processes. Due to different data sets and reporting requirements, the information collected varies markedly between states and territories.

There is a need to publish data relating to institutional violence, including coercive treatment, in order to broaden public awareness and attention to the issue. For example, the NSW Mental Health Tribunal's 2013/14 report indicates rates of successful appeal against an involuntary treatment order were 37 of 2442 (1.5%), and that of 662 Electroconvulsive therapy cases not withdrawn or adjourned, there were 616 cases of approval without consent (93%). While not necessarily indicating procedural problems with the tribunal, these high rates of coercive or substitute decision-making warrant greater scrutiny and discussion than routine reporting.

Reporting on the extent of restrictive practices (seclusion and restraint) is again lacking and there is little consistency across states and territories to support understanding of the prevalence and extent of activities. For example, in WA, the Office of the Chief Psychiatrist released its first report into seclusion and restraint- restraint data was not available as it was not being consistently reported. In 2014, the National Mental Health Commission issued a media release calling for the improvement of data collection.

Systemic Issues- Workforce and Culture

Many visitors to hospital wards will still recognise, in 2015, the description offered in Burdekin, 1993 that:

> "The cards and the flower don't come because the facility is hostile, even to visitors… [There is a] disconnection from the community, from the family, from the friends, which is engendered in every way possible by a mental health facility[11]"

The isolation associated with institutional arrangements was found, by the Royal Commission into Child Sexual Abuse, to be a factor contributing to people's vulnerability. Unwelcoming spaces with

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[10] Complaints Resolution and Referral Services (CRRS) and National Disability Abuse and Neglect Hotline (The Hotline) Policies and Procedures. http://www.disabilityhotline.net.au/linkservid/034CEFFE-0043-24A5-2F77E0F490A96E57/showMeta/0/

[11] Burdekin, 1993, p.277

high controls on visitor access discourage regular contact of consumers in institutions with family members and supporters, who are also often informal advocates.

CoMHWA frequently hears consumers having negative experiences of care within public mental health services. They report limited staff contact or engagement with them during inpatient stays and a focus on psychotropic medications rather than psycho-social supports. Lack of respect and dignity in staff attitudes and poor communication is also frequently reported. For example, one consumer who was transported to hospital reported staff having small talk with each other throughout the 20 minute journey, as if he wasn't there at all.

The language of some clinical mental health services is in itself violent and coercive, punitive and stigmatising. It is rife for compliance with decisions to be equated with capacity and insight, leaving limited opportunity for consumers to exercise choice and control over their lives. Terms such as 'custody', 'kicking off', 'compliance', 'absconding' and 'apprehension' reveal custodial attitudes that are not conducive to dignity and respect and create a stigmatising link between mental illness and criminal behaviour that is not consistent with evidence. Consumers are more likely to be victims of crime, than they are to be criminal offenders. Language reveals attitudes of consumers as potential risks, rather than as people seeking sanctuary, and such attitudes undermine attention to issues of violence, abuse and neglect that consumers may be experiencing.

Mental Health Inquiry Legacies- Ways Forwards

Support for a Royal Commission

The number of inquiries and investigations into challenges associated with quality and adequate care provision to mental health consumers is overwhelming. Still more overwhelming is the inertia with respect to resolution of repeatedly identified challenges, and which led to the entitling of one such document, which reviewed 5 national mental health plans and 32 reports, *Obsessive Hope Disorder*.

To offer three key examples of system inertia in relation to institutional violence, abuse and neglect:

- In 1993, the Burdekin report (National Inquiry into the Human Rights of People with Mental Illness) documented sexual and physical assaults occurring on wards, and cultures of non-reporting of assaults, coercion and restrictive practices. Burdekin's launch speech, in the capacity of Federal Human Rights Commissioner and Chair of the Inquiry, noted:

  > "There are now well defined international standards applicable to a wide range of human rights problems confronting Australians affected by mental illness. This report

> repeatedly documents our failure to comply with these fundamental human rights standards[12]."

- 12 years later, in 2005, the *Not for Service Report* noted:

  > "universal concern about the implementation of this Standard [rights being upheld by mental health services]across Australia. The concerns…indicate the continuing vulnerability of people with mental illness, continued exposure to abuse and a lack of access to complaints procedures to identify systemic failures and provide personal redress.[13]"

- In the 1960s and 1970s, 24 patients were killed at Chelmsford by a psychiatrist through involuntary deep sleep therapy (sometimes in combination with LSD), which was finally investigated via a Royal Commission inquiry in NSW following media coverage[14]. In 2011, the NSW Chief Psychiatrist and NSW Mental Health Tribunal approved two patients to receive multiple electro-convulsive treatments without their consent, while under general anaesthetic for more than 2 days, requiring monitoring in intensive care[15].

Therefore, our primary recommendation is that a Royal Commission to be held in relation to institutional violence, abuse and neglect on the basis that:

1. The extent and prevalence of the issue will not be fully understood without a structured, supportive, extensive and genuinely independent process for survivors to come forwards with their testimonies, independent of mental health services and with clarity and confidence that their testimonies will be heard, believed and adequately addressed. This is primarily due to the fragmented nature and limited effectiveness of existing complaints and oversight systems that produce clear barriers and disincentives to disclosure, and thus an inaccurate picture of the violence that is endured;
2. The distance and isolation of formal submission processes from those most vulnerable to abuse and neglect due to their institutionalisation requires an extended process in which governments and agencies work together to identify and support survivors to come forwards,
3. Such a process for survivors does not currently exist;
4. Until such testimonies are gathered, there is also insufficient knowledge of practical steps mental health consumers put forward, based on their lived experience of faults in the system, to make concrete recommendations that will improve community understanding, reporting on and prevention of institutional abuse and neglect.

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[12] Burdekin, Brian. 1993. National Inquiry into the Human Rights of People with Mental Illness. Launch of Report. https://www.humanrights.gov.au/news/speeches/burdekin-national-inquiry

[13] Mental Health Council of Australia. 2005. *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia* P.143

[14] https://en.wikipedia.org/wiki/Deep_sleep_therapy; see also http://www.piac.asn.au/news/2013/02/deep-sleep-tragedy

[15] Phillips, Nicky with Corderoy, Amy. ECT patients under anaesthetic for two days, *Sydney Morning Herald*, 18 June 2011

5. Supporting whistleblowers and past and present witnesses is important in the process of collecting evidence, which a parliamentary Inquiry cannot facilitate in and of itself.

CoMHWA cautions that there are unique obligations and challenges presented by any Royal Commission in relation to institutional violence in mental health residential settings and institutions:

6. The situation of mental health consumers in relation to this federal inquiry is unique because of mental health legislation. Specific governmental laws apply to them that authorise practitioners to detain, seclude, restrain and to administer treatments without their consent. When mental health issues are viewed as a specific type of disability under the UNCPD, our society must be willing and open to debating the morality of discriminatory legal approaches for specific classes of people with disability, as opposed to universal approaches to situations for supporting decision-making capacity and mechanisms to prevent harm and support wellbeing where capacity is diminished.
7. Consumers would seek to bring before a Royal Commission both lawful and unlawful cases of violence, abuse and neglect that have caused personal harm and are morally objectionable.
8. There are significant stakes involved, and system inertia, that present barriers to a truly independent, rigorous re-thinking of our fundamental attitudes to the human rights to freedom, dignity and health of people affected by mental health issues.

CoMHWA further recommends that should a Royal Commission take place, that it be designed and overseen in partnership with survivors, and that it be specifically designed and framed as an Inquiry into Violence, Abuse and Neglect of People with Mental Health Issues and/or Disabilities, to engage with consumers and attend to these distinctive obligations and challenges.

Other Recommendations

Parity for Mental Health Consumers in UNCRPD Commitments

The mental health sector and disability sectors are largely separated. The UNCRPD as the fundamental human rights instrument inclusive of mental health consumers is not widely known, or used, by the mental health sector. Similarly, National Disability Strategy is the key implementation mechanism for Australia upholding its rights obligations under the UNCRPD. This is not currently widely known of, or used, by the mental health sector.

Strategies for human rights awareness, rights protection and for the elimination of violence, abuse and neglect of mental health consumers and people with disabilities should be harmonised so that mental health consumers' human rights are not overlooked in government action and reporting on its obligations under the UNCRPD.

Zero Tolerance Culture & Framework

CoMHWA supports zero tolerance of violence campaigns and initiatives being adopted within the mental health sector (such as, within the disability sector, the Zero Tolerance project undertaken by NDS).

Intrinsic to any effective zero tolerance cultural initiative and framework is the need for inter-government support, endorsement and leadership, in order to integrate activities with public reporting on progress.

Re-Sensitising Complaints Systems

Graeme Innes, former Disability Rights Commissioner, cautions of the risk that “crimes are turned into administrative infringements” when services and agencies fail to adopt a zero tolerance of violence approach. Complaints bodies and mechanisms need to have clear mechanisms and policies for responding to violence, abuse and neglect, and where they also have a leadership and advisory role in complaints, to have the capability to offer guidance to stakeholders in these issues. Standardised protocols consistent with rights under UNCRPD in areas of: the reporting of criminal conduct, good practice in victim support, and safeguarding mechanisms and resources, are important for increasing the capabilities of services and agencies to respond appropriately when abuse, violence or neglect is disclosed.

Lived Experience Partnerships and Co-Production

The design, delivery and evaluation of mental health services needs to be a partnership approach between the service and people with lived experience, in order to understand people’s needs, strategies, aims, strengths and resources. While the National Standards for Mental Health Services support consumer participation, the extent of meaningful consumer participation varies between services. Effective, robust and independent consumer participation is particularly critical in relation to services that exercise, and agencies that oversee, statutory powers to detain and treat mental health consumers without consent. Inter-government commitment and support for consumer-led participation and advocacy is an essential safeguard.

Legal and Advocacy Supports

Consumers who have their rights restricted under the Mental Health Act need to have guaranteed access to free, timely and appropriate legal services to represent them. Access currently varies between states and territories.

Gaps in the availability of advocacy services need to be investigated and addressed, and advocacy agencies need to be supported through shared protocols, training and resources to support victims of institutional violence, abuse and neglect.

Seclusion and Restraint Elimination Strategies

The National Mental Health Commission's 2015 position on seclusion and restraint, developed following major research into the issue, specifies:

> There is a lack of evidence internationally to support seclusion and restraint in mental health services. There is strong agreement that it is a human rights issue, that it has no therapeutic value, that it has resulted in emotional and physical harm, and that it can be a sign of a system under stress[16].

CoMHWA supports the Commission's recommendations, which include standardisation of definitions, nationally consistent reporting, targets and nationally consistent standards and guidelines. Connecting issues such as seclusion and restraint to Australia's UNCRPD obligations could support more assertive and timely reduction and elimination of practices. Additionally, seclusion and restraint are extreme practices that occur in a context of broader coercive and restrictive behaviours that facilitate them. This broader range of rights-restrictive practices need to acknowledged, addressed and eliminated from a zero tolerance standpoint.

Trauma-Informed Care

Trauma-informed care and practice is the practice of designing services and offering support with awareness, sensitivity and capability to better meet the needs of trauma survivors. CoMHWA endorses and supports joint advocacy for promotion of wide adoption of Trauma Informed Care and Practice, as advocated for by Mental Health Coordinating Council, ASCA (Adults Surviving Child Abuse) and other key partners[17].

Trauma Specific Services

Trauma-informed care and practice aims to reduce risk of traumatisation or re-traumatisation in services by sensitive and informed ways of working, and to better support trauma survivors to engage and connect with trauma specific services. However, ensuring trauma specific services are available which provide support specifically focused on individuals understanding and recovering from trauma is just as important as enabling services to deliver trauma informed care[18].

Trauma-Free Design

Some consumer survivors report no trauma background prior to entry into mental health services, and specifically attribute trauma to mental health services. This speaks to directly traumatic environments and practices that need to be addressed, in addition to the need to work sensitively with trauma survivors that may be more vulnerable to re-traumatisation by service approaches. For example, basic

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[16] http://www.mentalhealthcommission.gov.au/media/123607/Position%20Statement%20seclusion%20and%20restraint%20FINAL%20ENDORSED%2020%20MAY%202015%20(D15-676981).PDF
[17] http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx
[18] See further Kezelman, C & P. Stavropoulos. 2012. *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.* Adules Surviving Child Abuse.

arrangements for continuity of life while in hospital - privacy, visiting, communication and access to information, normal routine, basic comfort and choices need to be basic elements of service design to avoid prison-like environments.

Continuity of Supports and Alternatives to Hospital

Physical and geographic arrangements for care that enable people's ongoing connection to family, friends and community members are likely to reduce risks of institutional violence (e.g. Hospital in the Home programs, and home-stay environments). WA is making progress in developing alternatives to inpatient treatment, through Hospital in the Home and subacute accommodation options. Ensuring services and community-based accommodation normalise, invite and support such relationships in their service arrangements is important.