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Ending seclusion and restraint use in Victoria's mental health services: The implications for women of the Royal Commission's recommendations

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Abstract
This article discusses the recommendations of the Royal Commission into Victoria's Mental Health System relating to the reduction and elimination of the use of seclusion and restraint. The author focuses on the implications of these recommendations for women. She argues that the Royal Commission's proposals stand to benefit all mental health consumers but failed to address the full range of gender-specific experiences and needs of women. The Andrews government has committed to implementing the Royal Commission's recommendations, and the author identifies a range of issues that must be attended to in order to ensure these matters are dealt with.

Keywords
Mental health law and policy, law reform, Royal Commission, human rights, gender and the law

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The Royal Commission into Victoria's Mental Health System ('the Commission') was established by the Andrews government in February 2019 to report on 'how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future'.[1] The Commission heard evidence from consumers, family members and carers, mental health nurses, psychologists, psychiatrists and others about the many failings of the 'broken' system.[2] In its final report, published in February 2021, the Royal Commission concluded that a major overhaul of Victoria's mental health system was necessary. It made 65 recommendations to guide this process and published a five-volume report detailing how the recommendations should be implemented. The government committed to implementing all these recommendations.[3]

A centrepiece of the new system is a proposed 'Mental Health and Wellbeing Act' to replace the *Mental Health Act 2014* (Vic). One matter to be addressed in the proposed legislation is the use of restrictive practices, specifically seclusion and restraint, in designated mental health services.

[1] Victorian government, *Royal Commission into Victoria's Mental Health System—Letters Patent* (2019) 2.
[2] *Royal Commission into Victoria's Mental Health System* (Final Report, February 2021) vol 1, ix.
[3] Daniel Andrews, 'Statement from the Premier' (2 March 2021) https://www.premier.vic.gov.au/statement-premier-88.

Seclusion is defined as 'the sole confinement of a person to a room or any other enclosed space' that they cannot choose to leave,[4] while bodily restraint encompasses both physical (use of the body) and mechanical (use of a device) restraint 'that prevents a person having free movement of [their] limbs'.[5] The use of these practices is permitted under the existing statute where 'necessary' to prevent 'imminent and serious harm' to the person or others. Bodily restraint is also permitted where it is 'necessary' to administer medication or medical treatment to the person.[6] Seclusion and restraint can only be used where 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[7]

The Commission was critical of the high rates of the use of restrictive practices in Victoria compared to other parts of the country, and cited research evidence and testimony from mental health consumers and others about the serious harms they can cause.[8] It also noted the incompatibility of these practices with the requirements of the UN *Convention on the Rights of Persons with Disabilities*.[9] The Commission identified the need for both systemic change to reduce 'pressures on the system' and particular changes to the regulation and use of seclusion and restraint to address high rates of use. Significantly, it also recommended (and specified) annual reduction targets that will lead to the elimination of the use of these practices within 10 years.[10] The Commission articulated a detailed framework for these reforms in a 62-page chapter of its report and its suggestions are consistent with the growing body of research evidence on the effective reduction and elimination of seclusion and restraint and their replacement with alternative practices.[11]

In light of the established harms of seclusion and restraint, which include distress, trauma, injury, pain, humiliation, anger, fear and loss of dignity,[12] the reduction and elimination of these practices stands to benefit mental health consumers of all genders, including women. However, some matters specific to women mental health consumers were not mentioned or addressed in the Commission's final report.[13] These include a lack of recognition of the influence of gender stereotypes and gender inequality on women's treatment, inadequate consideration of the relationship between women's mental health needs and past experiences of trauma, and a failure to mention the necessity of recognising women's intersectional experiences and needs. These gaps create the risk that reform will

[4] *Mental Health Act 2014* (Vic) s 3.
[5] Ibid.
[6] Ibid ss 110, 113.
[7] Ibid s 105.
[8] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 298–9, 304–6, 322–326.
[9] Ibid vol 4, 299, 304–5.
[10] Ibid vol 4, 344–5.
[11] Piers Gooding, Bernadette McSherry and Cath Roper, 'Preventing and Reducing "Coercion" in Mental Health Services: An International Scoping Review of English-Language Studies' (2020) 142(1) *Acta Psychiatrica Scandinavica* 27.
[12] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 298–9, 304–6, 322–326.
[13] Regulation and research on the use of restrictive practices generally uses the terms 'sex' or 'gender' to refer to binary categories of female/male or woman/man and discussions of gender-related considerations in mental health service provision usually focus on the exclusion of women's perspectives, or perspectives other than men's perspectives, without explicit discussion of the perspectives of trans women consumers or gender diverse consumers. In this article, I intend references to women to include references to all people who identify as women; I also endeavour to note where further attention is required to incorporate the perspectives, needs and rights of consumers of all genders and gender identities, including trans and gender diverse consumers.

be inadequate to meet women's needs, address gender-specific forms of inequality and marginalisation or ensure that women mental health consumers enjoy their human rights.[14] This is of concern both for the 10-year period during which the Commission contemplated the ongoing use of restrictive practices, and for the 'elimination' era that is supposed to follow, because the latter will depend on the implementation of alternatives that better recognise consumers' histories, experiences and needs, some of which are related to gender.

In this article, I first outline why gender is a relevant consideration in relation to the use of seclusion and restraint on women in mental health services. I then assess the Commission's recommendations in relation to seclusion and restraint in terms of the extent to which they recognise and address those matters. I conclude by suggesting how Victoria's Department of Health and other bodies tasked with enacting the Commission's recommendations might ensure that gender considerations for women are incorporated effectively in the forthcoming legislation and supporting guidelines and policy. The Department of Health offered the first indication of the content of the legislation in 'Mental Health and Wellbeing Act: Update and Engagement Paper' ('the Department Paper') published in June 2021, and I also discuss the extent to which that document deals with the issues I raise.[15]

The relevance of gender in the design and regulation of mental health services

There is a relatively small body of literature addressing the use and regulation of restrictive practices on women in mental health services in Australia and overseas. This research suggests that at least two gender-related factors must be – but often are not – built into regulation and practice relating to the use of restrictive practices and other responses to women's distress, aggression or other hazardous or unwanted behaviour.[16] The first is that women's gender is not recognised as a relevant consideration in the use of restrictive practices or in the implementation of alternatives to that use. The second is that the association between women's mental health and their experiences of trauma is not dealt with appropriately in mental health services generally, or in responding to women's dangerous or undesirable behaviour more specifically.

The possibility that gender *matters* in the provision and regulation of mental health services, both in individual and structural senses, does not tend to be contemplated in the design of mental health systems. This manifests in different ways in different parts of the mental health system including, for example, the absence or inadequacy of processes for avoiding and addressing sexual assault and sexual harassment in mental health services, and a lack of women-only wards and other coordinated, woman-centred services.[17] The research literature suggests several problems in this regard relating to the use and regulation of restrictive practices. The first is a failure to acknowledge that interactions between staff and consumers, and staff decisions about using restrictive practices, can be influenced

[14] See, eg, *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) arts 5, 6, 12, 14–17, 25; Surabhi Kumble and Bernadette McSherry, 'Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective' (2010) 17(4) *Psychiatry, Psychology and Law* 551.

[15] 'Mental Health and Wellbeing Act: Update and Engagement Paper' (Victorian Department of Health, June 2021) https://engage.vic.gov.au/mhwa.

[16] Yvette Maker, 'Beyond Restraint: Gender-Sensitive Regulation of the Control of Women's Behaviour in Australian Mental Health and Disability Services' in Bernadette McSherry and Yvette Maker (eds), *Restrictive Practices in Health Care and Disability Settings: Legal, Policy and Practical Responses* (Routledge, 2021) 91.

[17] Fiona Judd, Sue Armstrong and Jayashri Kulkarni, 'Gender-Sensitive Mental Health Care' (2009) 17(2) *Australasian Psychiatry* 105; Victorian Mental Illness Awareness Council (VMIAC), *Zero Tolerance for Sexual Assault: A Safe Admission for Women* (Report, 2013).

by gender stereotypes and bias, such as beliefs that women's 'difficult' behaviour is intended to manipulate or get attention from staff.[18] A second problem is that staff are trained, and required, to respond to consumers' distress or aggression by trying to control them. Women who have been subject to restrictive practices (among others) suggest that these responses are not beneficial, and instead propose 'relational' approaches, such as staff taking time to talk with them, as a preferable and gender-appropriate alternative.[19] A third problem, identified by consumers and staff, is that the involvement of men in the seclusion or restraint of women ignores the risk of actual or perceived abuse of consumers.[20]

The other gender-related factor that generally is not, but should be, taken into account in the use and regulation of restrictive practices in relation to women concerns the association between women's mental health and their experiences of violence and abuse, and the potential that restrictive practices will traumatise or retraumatise them.[21] Research indicates that past trauma is a negative social determinant of women's mental health.[22] Women with disabilities are more likely than women without disabilities to have these experiences,[23] as are Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds and LGBT women with disabilities.[24] Restrictive practices like seclusion and restraint are not characterised in regulation or practice as forms of violence or abuse,[25] even though they usually involve bodily contact or restriction of movement contrary to (or regardless of) a person's wishes and women subject to them report that the practices are distressing, humiliating, traumatising and painful.[26] These include reports in multiple published studies that women who were restrained or secluded experienced flashbacks or otherwise recalled prior experiences of violence or abuse, with the involvement of male staff in these practices being

[18] Jennie Williams, Sara Scott and Sue Waterhouse, 'Mental Health Services for "Difficult" Women: Reflections on Some Recent Developments' (2001) 68(1) *Feminist Review* 89, 99, quoting unpublished research conducted by Sara Scott; see also Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (Virago, 1987).

[19] Ruth Gallop et al, 'The Experience of Hospitalization and Restraint of Women Who Have a History of Childhood Sexual Abuse' (1999) 20(4) *Health Care for Women International* 401; Williams, Scott and Waterhouse (n 18).

[20] Rebecca Fish and Chris Hatton, 'Gendered Experiences of Physical Restraint on Locked Wards for Women' (2017) 32(6) *Disability & Society* 790; Juliet Watson et al, *Preventing Gender-Based Violence in Mental Health Inpatient Units* (Research Report, ANROWS, 2020).

[21] Jayashri Kulkarni, *Women and Mental Health* (Position Paper, Australian Women's Health Network, 2012); Watson et al (n 20).

[22] Mental Health Complaints Commissioner (Victoria), *The Right to Be Safe – Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report* (2018).

[23] Tamsin Cottis, 'Introduction' in Tamsin Cottis (ed), *Intellectual Disability, Trauma and Psychotherapy* (Routledge, 2009) 1.

[24] Mental Health Complaints Commissioner (n 22) 50–1.

[25] Linda Steele, 'Disability, Abnormality and Criminal Law: Sterilisation as Lawful and "Good" Violence' (2014) 23(3) *Griffith Law Review* 467.

[26] Watson et al (n 20); see also Rebecca Fish, '"Behind This Wall": Experiences of Seclusion on Locked Wards for Women' (2018) 20(1) *Scandinavian Journal of Disability Research* 139.

described as a triggering or exacerbating factor.[27] The seriousness of these effects begs the conclusion that restrictive practices are simply incompatible with women's safety, recovery and human rights.[28]

Royal Commission recommendations: A promising but incomplete framework for change

Overview of the recommendations: Working towards elimination

The Commission made several recommendations to the Victorian government on the use of restrictive practices, some of which have the potential to address the harms described above. These recommendations included immediate action to reduce the use of all forms of seclusion and restraint, with the aim of elimination within 10 years; introducing legislative provisions to regulate the use of chemical restraint (which is not currently addressed in legislation); and developing a strategy for reducing the use of seclusion and restraint.[29] The Commission also recommended that the government support the development of several co-designed programs and supports with people with lived experience and mental health services including programs to identify service-specific priority areas, make workforce training available and support services to embed the Safewards program.[30] Safewards, which was developed and trialled in Victoria, is focused on the development of positive relationships and interactions between consumers and staff.[31]

The Commission's report set out the rationale and detail of its recommendations in relation to seclusion and restraint. It recited widespread concern about the negative impacts of restrictive practices, their prevalence in Victoria's mental health system and factors contributing to their use; described the structure and character of a future mental health system without seclusion and restraint; and sketched a 'vision' for their elimination grounded in research evidence.[32] Some, but not all, of the gender-specific concerns described above were identified, or at least indirectly captured, in the recommendations and associated guidance.

Recommendations and guidance that could benefit women

Several elements of the Commission's recommendations, while not gender-specific, called for reforms that could address women's needs and experiences, and broader gender issues. For example, the Commission's report was critical of the high rates of seclusion and restraint use in Victoria.[33] It acknowledged the scope and severity of the potential harms to consumers of restrictive practices, and the potential of these practices to adversely affect family, carers, supporters and staff and to undermine the therapeutic relationship.[34] The Commission did not discuss the gendered impacts of these practices, but its conclusion that seclusion and restraint use must be reduced, and eventually eliminated, is likely to benefit women and all consumers in reducing and avoiding these consequences.

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[27] Gallop et al (n 19); Watson et al (n 20); Mary E Johnson, 'Being Restrained: A Study of Power and Powerlessness' (1998) 19(3) *Issues in Mental Health Nursing* 191; G Bonner et al, 'Trauma for All: A Pilot Study of the Subjective Experience of Physical Restraint for Mental Health Inpatients and Staff in the UK' (2002) 9(4) *Journal of Psychiatric and Mental Health Nursing* 465.

[28] Maker (n 16).

[29] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 297.

[30] Ibid.

[31] Len Bowers, 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards' (2014) 21(6) *Journal of Psychiatric and Mental Health Nursing* 499.

[32] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 336.

[33] Ibid vol 4, 315–317.

[34] Ibid vol 4, 298–9, 304–6, 322–326

The Commission characterised the reduction and elimination of restrictive practices as non-negotiable goals due to their human rights implications and their incompatibility with 'a system that is safe for both consumers and staff, and that provides the highest standard of treatment, care and support'.[35] This is consistent with the research evidence, described above, that women experience these practices negatively, and that they are counter-therapeutic. The Commission acknowledged that reducing and eliminating seclusion and restraint would entail 'formidable challenges', but characterised the barriers to these goals as structural and surmountable.[36] It identified both 'changes that specifically seek to reduce seclusion and restraint' (such as improving infrastructure and facilities and improving workforce training and capabilities to implement alternative approaches) and 'reforms that deal with the broader pressures on the system' (such as reducing the use of compulsory treatment and reducing reliance on hospital-based services) as necessary elements of reform.[37]

The Commission described the implementation of trauma-informed practice as another essential system-wide reform. This would mean ensuring that the system meets the needs of people who have experienced trauma through, for instance, recognising the effects of trauma and prioritising consumers' safety and control over their lives.[38] As mentioned above, trauma in childhood and/or adulthood is a negative social determinant of women's mental health[39] and seclusion and restraint use risk retraumatising women who have previously been subject to trauma, including abuse and sexual violence.[40] While the Commission did not mention the gendered aspects of these risks, its acknowledgment of the role of seclusion and restraint in creating and perpetuating consumers' trauma, and its call for this to be eliminated on the basis that it conflicts with trauma-informed care, are also consistent with gender-sensitive service provision.[41] Unfortunately, the Department Paper did not identify trauma-informed practice as a central element of the new mental health system. Further scrutiny of the wording of draft legislative provisions and supporting guidance, when published, will therefore be necessary to ensure the system is truly trauma-informed, including in relation to restrictive practices use.

The Commission also discussed, and suggested, a small number of gender-specific considerations in relation to seclusion and restraint. It mentioned the need for new guidelines on restrictive practices that include 'recognising gender and trauma history'.[42] It did not elaborate on the relevance of gender here, but this suggestion is consistent with assertions in the research literature that women's perspectives, experiences and requirements must be explicitly identified and addressed by services.[43] The Commission also suggested that gender-separation in bedrooms, bathrooms, high dependency units and other places could reduce the use of seclusion and restraint.[44] This relates to a recommendation earlier in the report that all new mental health inpatient facilities be built and

[35] Ibid vol 4, 300.
[36] Ibid.
[37] Ibid vol 4, 312; see also 302, 341.
[38] Linda Rosenberg, 'Addressing Trauma in Mental Health and Substance Use Treatment' (2011) 38(4) *Journal of Behavioral Health Services & Research* 428; *Trauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform across Mental Health and Human Services in Australia – A National Strategic Direction* (National Trauma-Informed Care and Practice Advisory Working Group, Mental Health Coordinating Council, 2014).
[39] Mental Health Complaints Commissioner (n 22) 50–51.
[40] Gallop et al (n 19); Watson et al (n 20); Johnson (n 27).
[41] For example, *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 301, 304.
[42] Ibid vol 4, 346.
[43] Gill Aitken and Kate Noble, 'Violence and Violation: Women and Secure Settings' (2001) 68 *Feminist Review* 68.
[44] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 303.

designed to permit gender separation in all bedrooms and bathrooms (and communal spaces as required), that existing high dependency units in inpatient facilities allow for gender-based separation by mid-2022, and that other existing inpatient facilities be reviewed and retrofitted to achieve gender-based separation 'where possible'.[45]

Improvements in the gender-sensitivity and safety of mental health services – if they are deemed to be 'possible' – are indeed likely to have positive implications for women in relation to the incidence and use of restrictive practices. Research with women who have been subject to restrictive practices indicates that relational approaches to service provision may also be important in avoiding the use of seclusion and restraint and providing safe and therapeutic services for women.[46] As touched on above, the Safewards program is focused on improving relationships and promoting positive staff-consumer interactions, meaning the Commission's recommendation that the Victorian government continue to support it, and related recommendations about the need for appropriate workforce experience, skills, staff numbers and training, are all likely to encourage services that increase relational security and better meet women's needs.[47]

Issues that did not receive enough attention from the Commission

The Commission's report did not recognise and propose responses to all the issues described earlier in this article. The Commission acknowledged that a range of factors can influence the use of seclusion and restraint and listed many of these factors, including service culture, staff team composition and capabilities, inappropriate physical environments and conditions and lack of resources to respond to people in crisis and distress.[48] It did not, however, mention the potential influence of gendered expectations, gender stereotypes and gender discrimination on staff decisions about using restrictive practices on women; for example, expectations about appropriate emotional expression and behaviour for women, and about the motivations behind women's behaviour.[49]

Some of these matters were identified in the Department Paper, which proposed the inclusion of explicit reference to gendered expectations and needs, and gender inequality, in the 'objectives' and 'principles' sections that will appear at the beginning of the new legislation.[50] While this is a good start, Penelope Weller has cautioned that high-level principles cannot be a replacement for enforceable provisions.[51] Indeed, the Commission noted that efforts to achieve 'safe, responsive and compassionate' individual treatment were 'largely undermined by inadequate system level support and accountability' despite there being existing legislative requirements to recognise and respond to 'individual needs' in regard to a range of characteristics, including gender.[52] This suggests the need for stronger monitoring, oversight and enforcement mechanisms (which were recommended by the

[45] Ibid vol 1, 581.
[46] For example, Aitken and Noble (n 43); Clive G Long et al, 'Effective Therapeutic Milieus in Secure Services for Women: The Service User Perspective' (2012) 21(6) *Journal of Mental Health* 567; Georgie Parry-Crooke and Penny Stafford, *My Life: In Safe Hands?* (Research Report, London Metropolitan University, 2009).
[47] Bowers (n 31); Maker (n 16) 100.
[48] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 320ff.
[49] See Maker (n 16) 93–95.
[50] Victorian Department of Health (n 15) 9–11.
[51] Penelope Weller, 'The Contradictions of Gender: Women, Men and Violence in Mental Health Research-Policy, Law and Human Rights' (2016) 25(1) *Griffith Law Review* 87.
[52] *Royal Commission into Victoria's Mental Health System* (n 2) vol 3, 245; see *Mental Health Act 2014* (Vic) s 11(1)(g).

Commission)[53] as well as legislative provisions that directly address gender-related requirements in relation to restrictive practices. For example, concerns raised by consumers about the gender of staff involved in applying seclusion and restraint could be addressed via a legislative provision requiring services to consult users about their preferences on this matter.[54]

The Commission called for 'comprehensive, accessible and timely' reporting of data on seclusion and restraint use,[55] including developing and reporting a 'suite of measures' for this purpose.[56] It also recommended the establishment of a statutory authority, the Mental Health and Wellbeing Commission, to conduct a range of independent oversight functions including monitoring the use of seclusion and restraint.[57] The Royal Commission did not, however, emphasise that data collection, monitoring and reporting should involve the disaggregation of this data according to gender and other demographic characteristics.[58] National data published by the Australian Institute of Health and Welfare (AIHW) does not currently include such data;[59] the Victorian Mental Illness and Awareness Council (VMIAC) also publishes annual reports on seclusion rates using publicly available data, although this too is aggregated and VMIAC has called for the publication of much more comprehensive data.[60] Without this, the experiences and needs of women, including women across all demographics and identity categories, may not be captured or understood, precluding accurate assessment of whether reduction and elimination efforts are adequately tailored to them.

In its few explicit references to gender and restrictive practices, the Commission did not acknowledge that women's needs and experiences (including experiences of marginalization and oppression) may differ according to multiple, potentially intersecting, dimensions of difference such as sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, disability or age.[61] This is despite, for example, the disparities in the prevalence of trauma among different groups of women described earlier in this article.[62] While the Commission acknowledged that recovery-oriented and trauma-informed practice are essential precursors to the elimination of seclusion and restraint,[63] the final report did not discuss the need for these to be sensitive to gender and other potentially intersecting dimensions of difference. Nor did it offer concrete recommendations of measures to mainstream trauma-informed practice in relation to restrictive practices, making it less

[53] The Commission addressed these governance issues in chapters 3, 27 and 30, among others: *Royal Commission into Victoria's Mental Health System* (n 2) vol 1, 4.
[54] Gallop et al (n 19); Watson et al (n 20); Bonner et al (n 27). The gender of staff is already addressed in legislative provisions concerning personal searches: *Mental Health Act 2014* (Vic) s 355(6)(b).
[55] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 330.
[56] Ibid vol 4, 345.
[57] Ibid vol 4, 226.
[58] The Commission did note that the Chief Psychiatrist's annual report provides data on the number of episodes of seclusion and restraint by age and gender: ibid vol 4, 330.
[59] 'Mental Health Services in Australia: Restrictive Practices', *AIHW* (Web Report, 2021) https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices.
[60] VMIAC, *Seclusion Report #2* (2020) 18 https://www.vmiac.org.au/vmiac-seclusion/.
[61] The Commission did discuss intersectionality and the need to take an intersectional approach to mental health service delivery in general in other parts of its final report and in its earlier interim report: *Royal Commission into Victoria's Mental Health System* (n 2) vol 3, 211; *Royal Commission into Victoria's Mental Health System* (Interim Report, 2019) 50.
[62] Mental Health Complaints Commissioner (n 22) 50–51.
[63] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 300, 341.

likely that these will be integrated into the new system. Such measures may include individualised planning mechanisms that require services to sensitively discuss users' experiences of trauma and other gender-related requirements, possible triggers for behaviours that might precipitate staff's use of seclusion and restraint, and strategies to avoid these practices.[64]

Similarly, the Commission's final report did not discuss the importance of ensuring that alternatives to seclusion and restraint are sensitive to gender. There is a valuable body of evidence on the implementation of alternatives, but further research is needed about whether these alternatives meet the needs and perspectives of all consumer cohorts, including women, girls and gender-diverse consumers.[65] Attention to these gaps would ensure that the reduction and elimination goals are appropriate for women and people of all genders.[66]

A further gap relates to the Commission's observation that consumer leadership and participation is one of the 'critical elements for eliminating seclusion and restraint'.[67] The Commission recommended that reduction and elimination efforts involve 'co-design with mental health and wellbeing services and people with lived experience'.[68] The importance it placed on co-design and consumer involvement is consistent with recommendations from researchers and advocates that women and others who have been subject to these practices and/or have experienced trauma must be involved in the re-design of services, policy and regulation.[69] Without explicit mention of the importance of involving the full diversity of consumers, including women and people of all genders, and of the need to enshrine co-design obligations in legislation and policy, there is a risk that 'co-design' will become tokenistic or unrepresentative. This gap was not remedied in the Department Paper, with that document suggesting the forthcoming draft legislation will not even identify co-design as a guiding principle.

Conclusions: Working towards a gender-sensitive system

The Commission's recommendations about reducing and eliminating restrictive practices, and especially the detailed, evidence-based guidance it provides for implementing those recommendations, has the potential to bring about major, positive changes to Victoria's mental health system. While reduction and elimination of these practices is now a widely accepted goal across Australia's mental health jurisdictions, the imposition of a ten-year timeframe has placed greater urgency on reform efforts, especially because it is accompanied by a recommendation of immediate and ongoing reduction in the period preceding elimination.[70] Ten years is still a long time, and there is a risk the goal will be lost or abandoned in the intervening period, with detrimental implications for women and other consumers.

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[64] Päivi Soininen et al, 'Secluded and Restrained Patients' Perceptions of Their Treatment' (2013) 22(1) *International Journal of Mental Health Nursing* 47; see Maker (n 16) 108–109 for a discussion.

[65] Gooding, McSherry and Roper (n 11).

[66] Maker (n 16) 110–111.

[67] *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 336.

[68] Ibid vol 4, 297.

[69] Colleen Clark et al, 'The Role of Coercion in the Treatment of Women with Co-Occurring Disorders and Histories of Abuse' (2005) 32(2) *The Journal of Behavioral Health Services and Research* 167, 180; Cath Roper et al, 'Ending Restraint: An Insider View' in Bernadette McSherry and Yvette Maker (eds) *Restrictive Practices in Health Care and Disability Settings: Legal, Policy and Practical Responses* (Routledge, 2021) 16.

[70] Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee, *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint* (Principles Document of the Australian Health Ministers' Advisory Council, 15 December 2016; *Royal Commission into Victoria's Mental Health System* (n 2) vol 4, 344–5.

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If the elimination goal is to be achieved, and for its benefits to be enjoyed by woman mental health consumers, the Victorian government must ensure that it addresses the gaps in the Commission's recommendations – and in the Department of Health's initial response to them – relating to women's experiences and needs. This requires, for example, ensuring that an intersectional gender lens is applied in all activities relating to the implementation of the Commission's recommendations and throughout the proposed Mental Health and Wellbeing Act; prioritising the leadership and involvement of the full diversity of consumers of all genders in the implementation of the Commission's recommendations; and recognising and addressing shortcomings of the data and evidence base in relation to gender-related experiences and needs.[71] These include assessing the effectiveness of seclusion and restraint alternatives for the full diversity of women and consumers of all genders; working with consumers and consumer representatives to develop programs and supports that will be effective in reduction and elimination efforts; and gathering and reporting gender-disaggregated data in relation to seclusion and restraint use and reduction efforts.

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[71] This intersects with the proposals regarding research and innovation in Chapter 36 of the Commission's report: *Royal Commission into Victoria's Mental Health System* (n 2) vol 5, 119.