



# Access and Injustice: An Intersectionality-informed Analysis of Victorian Mental Health Policy in Australia

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**ABSTRACT** *The use of compulsion and restrictive interventions in mental health care has been linked to social factors including poverty and marginalization. Using an intersectionality-informed analysis of key Victorian mental health policy documents released over the past decade, we identified a consistent lack of attention to the role played by race, socioeconomic status, and other forms of marginalization in the increased likelihood of compulsory treatment. Although policymakers have strived to consider the role of social determinants in catalyzing or mitigating mental distress, this social framework is often displaced by a consistently dominant biomedical approach to mental illness, which emphasizes identifying diagnoses and providing clinical treatment. This paper critically examines the stated intentions of mental health policy in Victoria, Australia, and the recent recommendations of the Royal Commission into Victoria's mental health system. We found that policies and recommendations for reform tend to express an intention to decrease the use of compulsion and restrictive interventions. However, the assumption expressed in reforms is that compulsory treatment is the result of systematic failure to provide treatment through other less intrusive avenues, thus neglecting deliberate discussion and action on the intersecting social factors that directly contribute to compulsory treatment.*

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## **Introduction**

On March 2nd, 2021, the Victorian Government released the *Royal Commission into Victoria's Mental Health System Final Report*, granting users and providers of mental health services with the foundations of a reimagined mental health system (State of Victoria, 2021a, 2021b). The Royal Commission was appointed on February 22nd, 2019. On the day of its inauguration, the premier of the State of Victoria, Daniel Andrews, echoed the sentiments of other elected officials, service providers, users of mental health services, advocates, and scholars in recognizing the current system as broken and ineffective (State of Victoria, 2021a). After two years of evidence gathering, the Royal Commission generated a *Final Report* containing 65 recommendations, inclusive of nine recommendations released in an earlier *Interim Report* (State of Victoria, 2021a). Together, these documents comprise six volumes and well over 3,000 pages, all intended to inform an ambitious redesign of Victoria's mental health and wellbeing system (State of Victoria, 2021a, 2021d). The Victorian government subsequently agreed to implement all 65 recommendations, using the findings as a justification for service transformation and improvement initiatives (Department of Health, 2024).

The *Final Report* of the Royal Commission addresses the already high and growing rate of compulsory treatment in Victoria's mental healthcare system. There has not been any sustained reduction in compulsory treatment (in both in-patient and community settings) since the passage of the *Mental Health Act 2014* (Maylea, 2022), despite the expressed intentions driving the Act including an emphasis on less restrictive practices (Light, 2019; Mental Health Tribunal, 2020; State of Victoria, 2021d). The rate of people subjected to Community Treatment Orders (CTOs) per 100,000 population has fluctuated from 55 in 2005 (Light et al., 2012a) to 76.4 in 2017 (Light, 2019), which is the most recent available data. The state of Victoria has consistently exhibited one of the highest rates of people subject to CTOs per 100,000 population in Australia since data on this subject has been collected (Light, 2019; Light et al., 2012a). Consistent with international findings, there is evidence that marginalized communities within Australia are more likely to be subjected to compulsory treatment. For example, Indigenous Australians comprise roughly three percent of Victorians actively receiving compulsory treatment, while representing only about 0.8% of Victoria's total population (State of Victoria, 2021d). Individuals from culturally and linguistically diverse backgrounds (CALD) are more likely to receive compulsory treatment orders, and the likelihood increases when language barriers necessitate the use of an interpreter (Moss et al., 2019).

There is inconsistency across Victoria's mental health services in the use of compulsory treatment (Victorian Agency for Health Information, 2022) and it appears that the use of compulsory treatment is potentially impacted by a person's address, income, the colour of their skin and what language they speak; it is not necessarily only used as a last resort by some services (Brophy et al., 2021). We will argue that these, and other social determinants of compulsory treatment, have been neglected in key policy documents and current recommendations for reform in Victoria.

The Royal Commission's recommendations, like policies before it, envision an empowering mental health and wellbeing system that simultaneously retains its right to deprive its users of autonomy. Whether it is possible for a system to empower users while also depriving them of autonomy is contested (Al-Azzawi, 2016). Hence the recommendations focus on trying to "solve" the problem by investing in more services and treatment options, which can address the failures caused by inadequate or non-existing services. By doing so, the Commission's findings imply that the system can be steered away from being crisis driven, and thus able to make compulsory treatment unnecessary (State of Victoria, 2021d). What is left unproblematized in this response, however, is a social perspective that genuinely challenges the biomedical dominance in the service system.

In this paper we draw on aspects of an Intersectionality Based Policy Analysis (IBPA) (Hankivsky, 2012) and Carol Bacchi's (2012) "What's the Problem Represented to Be?" approach to explore two influential Victorian mental health policies; *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019* (hereafter called *Because Mental Health Matters*) (Mental Health & Drugs Division, 2009), and its follow-up, published in 2015, titled *Victoria's 10-Year Mental Health Plan* (hereafter called *The 10-Year Plan*) (Department of Health & Human Services, 2015). Rooted in an intersectional lens toward social problems, the IBPA is informed by the post-structural practice of "problematization" developed by Bacchi (2012, 2016). This practice assumes that complex social problems (i.e., homelessness, addiction, poverty, mental distress) are constructed as problems in a variety of ways from different knowledge bases (i.e., policing, social work, psychology, public health, and medicine). In an IBPA approach one is trying to surface the ways in which intersecting and overlapping forms of oppression are or are not recognized in policy and how that then influences power relations that lead to or ameliorate inequities (Hankivsky, 2012).

Like previous policy initiatives, the Royal Commission (State of Victoria, 2021a) frames the disproportionate compulsory treatment of marginalized communities as a problem that hinges on timely access to appropriate mental health services. By illustrating that prior policies have reached the exact same conclusion by problematizing the issue in the same biomedical terms, we call into question the efficacy of the Royal Commission's plan, namely, to reduce compulsory treatment primarily through expanding the mental health system.

## Background

The *Final Report* (State of Victoria, 2021a) observes that, through the practice of compulsory treatment, the mental health system is contributing to traumatizing and re-traumatizing those it seeks to support. It systematically makes the case that within the current system, “human rights are breached unjustifiably through excessive use of coercive practices” (State of Victoria, 2021b, p. x). As a resolution to the problem of harm cultivated by the current mental health system, the Royal Commission’s *Final Report* recommends that the mental health system continue to have recourse to compulsory treatment only as a last resort when other avenues for less intrusive means of treatment are unavailable or have failed (State of Victoria, 2021d, p. 361). Thus, the recommendations include a new *Mental Health and Wellbeing Act* (State of Victoria, 2021d, p.11) that functions to renew the powers of the mental health system to treat Victorians on a compulsory basis, with built-in measures to reduce rates and negative impacts of compulsion and restrictive practices including seclusion and restraint.

The *Mental Health and Wellbeing Act*, which commenced on September 1st, 2023, currently provides the state of Victoria with legal parameters within which psychiatric services are delivered (Mental Health & Wellbeing Act, 2022). Previously, compulsory treatment was legislated by the *Mental Health Act 2014* (Mental Health Act, 2014) which came into force following a review of the *Mental Health Act 1986* (Mental Health Act, 1986), which the former ultimately replaced. The *Mental Health Act 2014* developed criteria for compulsory care that was intended “to ensure that assessment or treatment is given in the least restrictive way possible with the fewest restrictions possible on rights and dignity.” (Parliament of Victoria, 2014, p. 474). Legislation that only permitted compulsory treatment when there is “no less restrictive means” (Mental Health Act, 2014, p. 16) available did not prove effective in reducing the overall prevalence of compulsory assessments and treatments, given that rates of compulsory care continued to rise steadily following the passage of the *Mental Health Act 2014* (Katterl & Maylea, 2021).

The development and commencement of new legislation in 1986, 2014 and 2022 both coincided with and facilitated major shifts in the state of Victoria’s service delivery landscape, including *how* compulsory services are administered. Deinstitutionalization and decreasing length of inpatient admissions, now down to an average of 14 days (Australian Institute of Health & Welfare, 2024) has required emphasis on the community as the primary site for treatment and increased reliance on Community Treatment Orders (CTOs). CTOs are thought to enable earlier discharge from hospital, continuity of care and prevention of readmission – even without strong evidence that the latter is being achieved (Harris et al., 2019; Light, 2019).

However, CTOs have also been widely reported to be experienced as punitive and as a form of surveillance by those subjected to orders (Lawn et al., 2016). In Lawn et al.’s (2016) study of Southern Australians currently on

CTOs, no respondent portrayed or understood mental health services as having a “helping, therapeutic role” (p. 6). Previous to the Royal Commission, CTOs were largely neglected in state mental health policy despite their prevalence and impact; this lack of attention, combined with the lack of uniform national data on CTO use, furthers the marginalization and discrimination of people subject to such orders (Light et al., 2012a, 2012b, as cited in Light, 2019).

Brophy and McDermott (2003) highlight important social, economic, and political factors that have influenced the uptake of CTOs and have led to unintended consequences. Deinstitutionalization, and the increased emphasis on community-based care, which both the *Mental Health Act 1986* and *Mental Health Act 2014* intentionally facilitated, aligned with an increase in the use of CTOs.

CTOs have been identified as enabling service providers to stymie the risk of a patient not gaining access to mental health services while living in the community, hence being an unintended mechanism to deal with systemic problems (Brophy & McDermott, 2003, p. 85; Corring et al., 2017; Light, 2019; Walker et al., 2019). CTOs are also argued to have a “deskilling” effect, as reliance on coercion to achieve compliance has replaced the need for highly skilled treatment options that are more appropriate to peoples’ needs (Brophy et al., 2006, p. 472). The use of CTOs often remains invisible to the wider public, and this lack of awareness of human rights violations reduces the political opportunities for change (Campbell et al., 2006).

### *Social Determinants of Compulsory Treatment*

It is well established that there are social determinants of mental health (Rotter et al., 2022). These are given significant attention in the policies addressed in this paper. However, in this analysis, we are interested in the sociocultural and socioeconomic determinants of compulsory treatment (Brophy & McDermott, 2003; Brophy et al., 2006; State of Victoria, 2021d). Among the poorest one-fifth of Australians, one in four people have psychological distress at a high or very-high level; this compares to about one in 20 people in the richest one-fifth of Australians (Enticott et al., 2018). Economic deprivation on an individual level and at the population level has been associated with increased risk for involuntary hospitalisation (Walker et al., 2019). Indigenous Victorians are more likely to be involuntarily treated, making up approximately three percent of Victorians subjected to compulsory treatment orders even though they only make up about 0.8% of the population (State of Victoria, 2021c). There are also high levels of post-traumatic stress disorder and other mental health disorders among refugees and asylum seekers in Australia (Shawyer et al., 2017), and this puts them at greater risk of experiencing compulsory treatment. While it is unclear why certain groups are more likely to be over-represented on compulsory treatment orders (Brophy & McDermott, 2003), the impact of colonization, systemic racism and ethnocentrism may help to explain why

Indigenous and CALD populations have higher rates of compulsion (Kisely et al., 2020).

To understand the role of policy in why people from racialized backgrounds are more likely to experience compulsion, we use an intersectional methodology that centres how the problem of mental illness and compulsory treatment are understood. Intersectionality is a theoretical and methodological framework that emerged from Black and Indigenous feminist activism that argues that oppression and privilege are intersecting and overlapping social experiences and aims to uncover how systems of power operate and impact on populations (Hancock, 2016; Hill Collins & Bilge, 2016). By applying this methodology, outlined below, we hope to demonstrate that the way Victorian mental health policy approaches the problem of mental illness enables compulsion of already minoritized people.

### **Methodology**

IBPA uses a series of questions that are intended to illustrate how problems are conceived in policy. Rather than accepting the framing of problems as given, critiquing problematization can bring into perspective some of the implicit assumptions upon which this framing is based. By applying IBPA based on Hankivsky's (2012) guidance, we strive to reveal biases and assumptions as these relate to experiences of oppression based on indigeneity, race, gender, ethnicity, age, and sexuality, that might otherwise remain invisible. As such, our analysis revolved around applying the following two questions to each policy: what is the policy problem under consideration? (how do the documents position and describe the problem?); and what inequities actually exist in relation to the problem?

Drawing on the IBPA questions, two key policies produced by the government of Victoria that continue to shape system responses were explored: the first, titled *Because Mental Health Matters* (Mental Health & Drugs Division, 2009) is based on consultations with 1,200 stakeholders and over 240 written submissions commissioned by then Minister of Mental Health Lisa Neville. The second policy analyzed, titled *The 10-Year Plan* (Department of Health & Human Services, 2015), builds on *Because Mental Health Matters* and incorporates feedback from further public consultations; more than 1,000 people participated in public consultation events, over 10,000 people visited the consultation website and over 1,000 made online comments and written submissions. The findings from our analysis of these two important background policy documents were subsequently used to inform the analysis of the Royal Commission's findings and recommendations (State of Victoria, 2021d).

## Analysis

### *Representations of the Problem – Social and Biomedical Modes of Problematization*

Here we draw upon an IBPA framework (Hankivsky, 2012) to examine how the mental health system is problematized in *The 10 Year Plan* of 2015 and *Because Mental Health Matters* of 2009. *Because Mental Health Matters* and the *10 Year Plan* draw upon distinct, and in places disagreeing paradigms in their problematization of mental health. The complexity and scale of the problem of mental health that each policy puts forward emerges via this simultaneous commitment to multiple and conflicting paradigms.

One of these paradigms asserts that mental health is determined, at least in part, by collectively experienced and modifiable social forces. In the context of each policy, this paradigm inspires a very broad and inclusive understanding of mental health: the social factors considered relevant to mental health include the quantity or quality of an individual's "income, social status, education, employment, working conditions, access to appropriate health services and physical environment" (Mental Health & Drugs Division, 2009, p. 160). This iteration of mental health, which is conceptualized as etiologically tied to dynamic and diverse social forces, is understood to be something which *all* people residing in Victoria possess or experience: "mental health is everyone's business... It will take collective effort for all Victorians to experience their best mental health" (Department of Health & Human Services, 2015, p. 1). This paradigm is thus aligned with recognition of the evidence cited above that compulsory treatment is linked to social determinants and more likely to involve people who are marginalized.

The second paradigm draws on a biomedical understanding of mental health to construct a problem that is circumscribed by symptomatology and diagnosis. According to the biomedical paradigm, alleviating mental illness (i.e., reducing its prevalence and severity) is largely contingent on successful interactions with the mental health system. Biomedicalism interprets mental illness via clinically documented diagnoses and observable symptoms, and links these to the possibility of treatment. This paradigm is represented in the following:

The Victorian government funds public clinical mental health services that treat people with severe and enduring mental illness... Some people using clinical mental health services are treated as compulsory patients under the *Mental Health Act 2014* (people considered to be in need of immediate treatment to prevent serious deterioration in their mental or physical health or prevent serious harm to themselves or another person). (Department of Health & Human Services, 2015, p. 8)

The biomedical paradigm appears in these policies as the ends of a continuum, along which problems are constructed according to their own unique mixture

of individual and sociological considerations. Consider, for instance, the following passage:

The Victorian Government's reform vision is centered on the importance of mental health to the fabric of our society – to our family life, our relationships, our workplaces and our communities. We recognize good mental health as a critical element of our overall health and wellbeing at every stage of life. This means that mental health should be promoted and protected as seriously as physical health, and that mental health care must be an integral part of our wider healthcare system. We need to approach mental health problems as both a cause and a consequence of a wide range of other health and social problems. Our mental health response must embrace a broad spectrum of conditions, from anxiety, depression and conduct disorders, to personality disorders, eating disorders and schizophrenia. Some conditions clearly arise in response to life events and environments – hence are more amenable to prevention – while others are chiefly organic in origin. (Mental Health & Drugs Division, 2009, p. 21)

This statement, which constitutes the “Vision and Strategy” of *Because Mental Health Matters*, outlines the general scheme with which the social determinants of mental health and biomedical approaches are here integrated into policy. The relevance of social and biomedical factors to different problems – here considered collectively under the umbrella of mental health – are weighted differently depending on the problem under consideration: that is to say, the relevance of social and environmental factors to mental problems is thought to fluctuate in accordance with the nature of the particular problem. The conclusion of the passage intimates the role of problematization in prefiguring a solution: those conditions that arise in response to “life events and environments” are considered more amenable to preventive social solutions, and those that are “chiefly organic in origin” are thought to require biomedical intervention via the mental health system (Mental Health & Drugs Division, 2009, p. 21).

“Severe mental illness,” a term used in both policies and defined as referring “typically [to] schizophrenia or psychosis, bipolar disorder, or severe depression,” is thought to be largely contingent on interactions with the mental health system (Mental Health & Drugs Division, 2009, p. 163); here, the “severity” of illness is exacerbated by the absence of treatment. Addressing severe mental illness requires making mental health services to be available at “the right time in the right place” (Department of Health & Human Services, 2015, p. 10); for the “44% of Victorians with a severe mental illness,” failing to “systematically intervene [with specialist mental health care] early in the illness pathway results in relapse... and subsequently propels people to crisis” (Mental Health & Drugs Division, 2009, p. 93). Schizophrenia and psychosis (the “typical” referents of “severe mental illness”) are excluded from a list of “mental health problems” with “clear relationships [to] key social determinants”; policy here only connects “psychological distress, stress, anxiety and depression [to] poverty, discrimination, violence, unemployment and isolation” (Mental Health & Drugs Division, 2009, p. 39).

*What is Left Unproblematized in the Representations? – Revealing the Intersections*

This relative detachment of severe mental illness from the social sphere warrants further examination given the apparent social underpinnings of both “severe” mental illness and compulsory treatment. The data presented in both policies conforms to that more recently provided by the *Final Report* and other researchers, and demonstrates that Indigenous, CALD, racialized, and impoverished Australians experience severe mental illness at disproportionate rates and are subjected to involuntary commitment and community treatment orders at higher rates than the rest of the population (State of Victoria, 2021d). A study completed in 2009 found the CALD community to be subjected to compulsory treatment (all types) at a rate 15% higher than the general population (Mental Health & Drugs Division, 2009, p. 50).

The development of severe mental illnesses in individuals from CALD or migrant backgrounds, and the disproportionate compulsory treatment of this population is treated as a single phenomenon and jointly ascribed to the absence of timely and appropriate medical intervention:

CALD groups often have poorer mental health outcomes compared to Australian born people, typically presenting to services when their illness is more severe and experiencing higher rates of involuntary treatment. Access to culturally competent mental health care remains a key issue for CALD communities. (Mental Health & Drugs Division, 2009, p. 50)

This position is reiterated six years later in the *10 Year Plan* (Department of Health & Human Services, 2015). The disproportionate compulsory treatment of Indigenous people in Victoria is not acknowledged or discussed in either *Because Mental Health Matters* or *The 10 Year Plan*; a similar explanation to that applied to the CALD community, however, is repeated to account for the general rise of CTOs administered to all demographics:

The failure to systematically intervene early in the illness pathway results in relapse which could have been prevented in many cases, and subsequently propels people to crisis and the need for costly interventions which often involve police, ambulance services, and hospitalization... While Community Treatment Orders (CTOs) are an important element of community-based treatment, their increasing use is a cause of some concern. Other measures considered by this strategy to improve the capacity of the specialist mental health services to respond to people with severe and enduring mental illness should improve levels of voluntary engagement and reduce the overall need for CTOs. (Mental Health & Drugs Division, 2009, p. 93)

Compulsory treatment is thus ascribed to the system’s failure to provide appropriate and timely services on a voluntary basis (Mental Health & Drugs Division, 2009, pp. 30, 35, 50, 53). *The 10 Year Plan* here diverges by claiming that the *Mental Health Act 2014*, passed five years after *Because Mental Health Matters*, “has fundamentally changed compulsory mental health treatment”

and “minimized [its] use and duration” by placing “people with mental illness at the center of decision making” (Department of Health & Human Services, 2015, p.13). In reality, the rate of compulsory treatment in inpatient and community settings rose between 2009 and 2014 and has continued to rise since then (Light, 2019; Mental Health Tribunal & Mental Health Legal Centre, 2019; State of Victoria, 2021d). *The 10 Year Plan’s* statement attests to the high degree of confidence placed in the commitment from the *Mental Health Act 2014* to only provide compulsory treatment when “there are no less restrictive means reasonably available.” (Mental Health Act, 2014, pp. 16).

The capacity of mental health policy to think in social terms appears to break down when the subject matter shifts to compulsory treatment. Race, English fluency, and Indigeneity are minimized, and are considered relevant to compulsory treatment only in so far as they predict the degree of access an individual has to the mental health system. Further, the conditions created through compulsory practices become of secondary importance to the obligation to provide treatment. We see here the automatic and unspoken relegation of established social factors to relative insignificance (Walker et al., 2019). Advocating for a broader acknowledgement of social factors in general fails to provide an adequate account of the social effects of the mental health system itself, which functions in large part on a compulsory basis.

The biomedical explanation for compulsory treatment forces the mental health system onto the compulsorily treated person: the only solution it can imagine to compulsory treatment is the expansion of the mental health system to facilitate earlier interactions between individuals and the system. This does not leave any space for the refusal of the mental health system. It says, instead, that the only way of relieving this system of its coercive powers is by granting it the opportunity to provide treatment at another time and place. Its logic is problematic and self-perpetuating; whenever the mental health system reaches beyond the limits of consent, this is treated as proof of the need for this system’s further expansion. We can, instead, envision compulsory treatment as a social phenomenon, and ascribe its prevalence to the willingness of a powerful social actor – the mental health system and its practitioners – to act on patients without obtaining their willing consent. Considered socially, compulsory treatment no longer finds its root cause in the mental health system’s failures and absences, but in its ongoing willingness to overlook the social determinants of compulsory treatment and tolerate coercion.

### **Assumptions Guiding Representations of the Problem – The Royal Commission’s Final Report**

It will be argued here that the *Final Report* maintains the fundamental assumptions that underpin Victoria’s earlier problem representations in mental health policy development and implementation efforts (State of Victoria, 2021d).

The Royal Commission recommended the repeal and replacement of the *Mental Health Act 2014* with a new *Mental Health and Wellbeing Act* that is intended to support services to reduce compulsory treatment. The latter Act, as envisioned by the Royal Commission, would again enable compulsory treatment in both community and inpatient settings. The Royal Commission intends the new Act to ameliorate the problem of compulsory treatment (which, to reiterate, it simultaneously makes possible) by integrating measures to reduce the use and duration of compulsory treatment: these include providing non-legal advocacy for individuals placed on, or at risk of being placed on, compulsory treatment orders, and a broader adoption of supported decision-making practices (State of Victoria, 2021d). The likelihood of receiving advocacy will be strengthened under the new Act by making it something that people need to opt out of rather than opt into, thereby guaranteeing, in theory, access to advocacy services to all Victorians placed under a treatment order (State of Victoria, 2021a, p. 14). Despite the fact that the Royal Commission explicitly criticizes the *Mental Health Act 2014* for enabling a psychiatrist to compulsorily treat a person “in direct contradiction with their expressed preferences” as outlined by an advanced statement (State of Victoria, 2021d, p. 31), the new *Mental Health and Wellbeing Act*, which was implemented in September 2023, similarly allows psychiatrists to “override” advanced statements (Engage Victoria, 2021, p. 17).

The Royal Commission’s call for more complete data on the socio-economic demographics that correlate with being placed on a compulsory treatment order indicates a willingness to consider compulsory treatment in a new light (State of Victoria, 2021d). The Commission thus promises a more complete picture of compulsory treatment to come, where the involuntary interaction between service administrator and service recipient is presented in more saturated detail. This saturated representation of the social conditions, elements, and actors involved in compulsory treatment is, however, largely anticipatory. The *Final Report*, like the policies that preceded it, understands the practice to be the product of an under-resourced and inadequate system: the mental health system’s coercive activity is understood as the culmination of its failures and absences. The *Final Report* thus concludes that the system can continue to practice compulsory treatment while effectively rendering the practice obsolete by expanding the mental health system, rather than directly eliminating the practice:

The Commission recognises that achieving a meaningful reduction in the use and duration of compulsory treatment depends on consumers having ready access to a diverse mix of voluntary treatment, care, and support. (State of Victoria, 2021d, p. 412)

Similar to its predecessors, the *Final Report* argues that in order to reduce compulsory treatment the services that it offers must be expanded; however, more emphasis is now placed on the existing environment of the system, as opposed to the role its absence plays in exacerbating mental illness:

Witnesses told the Commission that despite the Mental Health Act defining the limited circumstances under which compulsory treatment can be used, and the efforts of many to reduce compulsory treatment, constraints on the mental health system have contributed to an increase in its use... While there are many factors that have led to this, chief among them is that the workforce has not been supported with resources to reduce the use of compulsory treatment, such as having the time to engage with people. The Commission considers both the rate and duration of compulsory treatment orders in the Victorian mental health system are too high, and that it is a systemic failure that compulsorily treating a person has become, in some instances, the default response... A concerted effort must be made to reduce the use and duration of compulsory treatment throughout Victoria so it is only used as a last resort. To achieve this objective, a well-resourced system that can offer a diverse range of treatment, care and support options in line with a person's needs and preferences, particularly in community settings, must be available. (State of Victoria, 2021d, p. 364)

In general, the *Final Report* reveals more about the system through which compulsory treatment unfolds. The prevalence of compulsory treatment is here attributed to a system that does not have time for its clients, while elsewhere submissions from public consultations are reproduced that detail the environments, the displays of force, and the fear, pain, and discomfort individuals are liable to experience via the systematic recourse to compulsory treatment (State of Victoria, 2021d). The problematization of compulsory treatment is still essentially framed, however, around what the system lacks, as is reflected by its recommendation regarding compulsory treatment: "Recommendation 55: Ensuring compulsory treatment is only used as a last resort" (State of Victoria, 2021d, p. 361).

The *Final Report* shows a greater willingness to consider the environments and experiences the mental health system creates via compulsory treatment but continues to justify the existence of compulsory treatment as necessitated by the system's failure to intervene at another place and time (State of Victoria, 2021d). Furthermore, the *Final Report* establishes a new commitment to generate data on compulsory treatment (State of Victoria, 2021d). This commitment is explicitly grounded in an identified need to build the "evidence base about why and how compulsory treatment is used and which groups are disproportionately affected, including any social determinants" (State of Victoria, 2021d, p. 422). However, a submission to the Commission by Lisa Brophy highlights that it is the social determinants of compulsion that need further elaboration. She writes: "data of this type would also identify what mental health services use or rely on compulsory treatment more frequently, enabling us to examine the reasons behind this increased use and the microcultures in those services" (Brophy, n.d., p. 27). The *Final Report* thus acknowledges the need for a more complete picture of the factors and conditions that drive compulsory treatment.

## **Conclusion**

The review of key Victorian mental health policy documents and subsequent interrogation of recommendations of the Royal Commission using an IBPA approach reveal that little attention has been paid to understanding how experiences of mental illness exist in a broader social context, where inequities related to social and structural factors such as colonialism, poverty and racism influence the likelihood of experiencing compulsory treatment. Further, the lack of recognition that the mental health system perpetuates inequities, and the high use of compulsory treatment is implied through the discourses that permeate these documents (e.g., by problematizing issues in CALD communities as the communities themselves being to blame for not readily accessing mental health services, rather than giving central importance to the cultural, social, and structural factors that may be contributing to increased experience of psychological distress and compulsory treatment).

Recognizing the role of the social in mental health in the policy we reviewed is predicated on the notion that only some types of mental distress are worthy of this recognition. That is, a hierarchy of illness is created, where the most severe mental illness is seen as somehow outside of the social and wholly attributed to biomedical causes. The result is that compulsory treatment continues to be upheld pertaining to certain kinds of illness and certain kinds of populations. Importantly, by obfuscating the profoundly socially embedded nature of compulsory treatment, biomedicalism restricts the ability of the mental health system to effectively understand its *own* activity. An alternative would be to understand all forms of mental distress as embedded in larger social and political contexts, revealing how societal inequities and discrimination play out in the mental health system, such that CALD and Indigenous populations are more likely to be subject to coercive practices. This recognition coupled with a true commitment to ending coercive practices and supporting and further developing alternatives has the potential to radically transform the system. Future research efforts to support the development of a more evidence-informed approach to reducing compulsory treatment should actively draw on the voices of people from racialized backgrounds with experience of compulsion and others who have experienced marginalization and stigma.

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