Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR CHRISTOPHER RYAN

I, Christopher Ryan, Consultation-Liaison Psychiatrist, of Westmead Hospital, Hawkesbury Rd, Westmead NSW 2145, say as follows:

1. I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2. I make this statement in my professional capacity as a consultation-liaison psychiatrist and researcher. The opinions in this statement are my own and are not made on behalf of the University of Sydney, Westmead Hospital or any other organisation.

Background

3. I am a Consultation-Liaison Psychiatrist and the Director of Consultation-Liaison Psychiatry at Westmead Hospital in New South Wales. I am also a Clinical Associate Professor with the University of Sydney and an Associate of Sydney Health Ethics.

4. I am the immediate past Chair of both the New South Wales Faculty of Consultation-Liaison Psychiatry and the Royal Australian and New Zealand College of Psychiatrists Committee for Advanced Training in Consultation-Liaison Psychiatry.

5. I am on the National Advisory Board of the *Australian and New Zealand Journal of Psychiatry* and I am a member of the Editorial Committee of *Australasian Psychiatry*.

Consultation-Liaison Psychiatry

6. Consultation-liaison psychiatrists provide psychiatric treatment and assessment to patients who are either in emergency departments or have been admitted to the general medical hospital for a physical health condition and who are experiencing mental illness as well as, or as a result of, that physical health condition.

7. Consultation-liaison psychiatrists have expertise in the interaction between physical health conditions and treatment and mental illness. For example, if a person presents to hospital with a heart attack and experiences depression, the consultation-liaison psychiatrist will assist with the depression. The depression may be related to, or as a result of, the heart attack, or it may be as a result of side effects of the treatment of the heart attack. The understanding of the interaction between physical conditions and

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

mental illness is our expertise. We are also required to have an understanding of the functioning of a hospital (including how people move through emergency departments).

8 There are a small number of people who practice as consultation-liaison psychiatrists. For example, Westmead Hospital has 950 beds and around six consultation-liaison psychiatrists, which is a good number of staff. In my view, we provide the best care for people who have mental illness in these environments.

9 There is evidence that consultation-liaison psychiatry provides benefits to individuals, but it does depend on how the benefits are assessed. In terms of a cost-benefit (cost of treatment versus cost of no treatment), the benefits can be hard to show. However, a recent report in the United Kingdom has found that there are benefits to this practice.[1].

Use of consultation-liaison psychiatry in the community

10 The model used for consultation-liaison psychiatry can be implemented in the community setting. While consultation-liaison psychiatrists have a specialised knowledge base, what we are doing in the hospital setting could be done, using the same model, in the community, and probably should be happening in the community already.

11 However, the benefit of the hospital setting is the immediacy in which people are seen, particularly as it is important to discharge people from hospital as soon as possible. One of the reasons we are well funded is that we can respond that day, most of the time. This immediacy of response is not likely to be possible in the community.

12 Further, while I am not an expert on what is happening in the community, my impression is that the funding models are not set up to allow this to happen effectively.

Compulsory treatment

Difference in approach between mental healthcare and other areas of health care

13 Until recently, mental health legislation around Australia permitted the compulsory treatment of a person who was competently refusing that treatment. The result was that people living with mental illness were denied a right to autonomy that everyone else was able to access.

14 Fortunately, the legislative position has changed, at least, to an extent. Most Australian jurisdictions (excluding Victoria, New South Wales and Northern Territory) have, at least, changed the legislative framework to add the absence of relevant decision making

[1] Parsonage M and Fossey M. (2011) Economic evaluation of a liaison psychiatry service. Available at: http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/centreformentalhealth/economic111.aspx.

capacity to the criteria that must be met before people can be given compulsory treatment.

15 In South Australia, Western Australia, Tasmania and Queensland and more or less also in the ACT, if you have decision making capacity regarding a particular mental health treatment and you are refusing that treatment, you cannot be subject to compulsory treatment. At least that's what the law says. I discuss further below the impact of the legislation in practice.

Effectiveness of compulsory treatment

Benefits to consumers, families and carers, community and services

16 Compulsory treatment can be of benefit to people. This is particularly so for people who lack decision making capacity and who have a serious mental illness that is threatening their life or significantly affecting their ability to function. When these people are making decisions about their mental health treatment that place themselves in peril, and there is no other way of providing treatment but by overriding their voiced preferences compulsory treatment saves lives.

17 Not only do these incompetent people with mental illness themselves benefit from compulsory treatment, but so do their friends and family, who without compulsory treatment may feel powerless to assist their loved ones.

18 Additionally, though this is very rare, some people with mental illness, may as a result of the illness, pose a risk to family, friends or others in the community. In these circumstances compulsory treatment may mitigate that risk.

19 Additionally, in some cases, compulsory treatment of people who lack the requisite decision-making capacity can lead to a person receiving treatment earlier than they would otherwise. This may not only benefit the person receiving treatment, but also their friends and family and may divert demand away from acute services (such as inpatient units) that would be required if the person's illness were not treated early.

20 While there are many people that require compulsory treatment because they lack decision making capacity, in my view, there are far more people experiencing involuntary treatment in this way than there should be.

Alternatives to compulsory treatment

21 The obvious alternative to providing compulsory treatment is to provide excellent care. This is because the more excellent care you provide, the less compulsory treatment you will have to give. If you are good at providing treatment you will provide compulsory

treatment less. However, one of the reasons we are not good at providing excellent care is because we overuse compulsory treatment.

22 While excellent care is expensive, time consuming, and a lot of effort, it is what we should be doing, regardless of whether compulsory treatment is involved or not.

23 I don't think the provision of excellent care requires any particular factors to be present in the individual, but at a systemic level there is a need for staff with a high level of skill and who are sufficiently resourced to take the significant time that is required to offer excellent care. The form that excellent care should take, for all varieties of mental illness are well described in the literature and there is no reason to suppose that these methods could not be used more widely in Victoria if sufficient resources were available.

Impact of compulsory treatment on therapeutic relationship between consumer and clinicians

24 In my experience, for most patients, compulsory treatment does not generally impede the therapeutic relationship between a consumer and a clinician (there are exceptions to this of course). Usually it comes down to establishing a good relationship with the consumer and this can be done in these circumstances, particularly if the reason for treatment is explained to the consumer.

Treatment criteria in practice

Appropriateness of criteria for use of compulsory treatment

25 On the harm criterion, jurisdictions across Australia are similar. To the extent that the wording differs between each jurisdiction, in practice this seems to have little effect. The threshold in Victoria is pretty low, but not so low that the harm need not be regarded as serious.[2] In Queensland, the word 'imminent' as well as 'serious' is used.[3] On paper, this would appear to raise the bar enormously, however in practice I do not think it does. That is, I do not think that practitioners read it that way. The 'serious harm' threshold as is the case in Victoria is an appropriate threshold, as long as there are other thresholds at play too. The other important thresholds are the least restrictive means and the capacity threshold.

26 It is arguable that the capacity criterion is in Victorian legislation. However, reasonable minds do differ on that. In my view, it is present in the Victorian legislation. However, the

[2] *Mental Health Act 2014* (Vic) s 29(b).
[3] *Mental Health Act 2016* (Qld) s 12(1)(c)(i).

question of whether it is in the legislation is, in my view, partly irrelevant because it is so obscure that it is not noticed (including by the Mental Health Tribunal).[4]

27 In my view, the issue is not with the treatment criteria per se, but how a legislative scheme operates in practice. That is, it is about how the people that operate the legislation (that are not lawyers) apply it in practice. In my view, it is often the case that legislative schemes are not applied in the way they are intended to.

28 This is demonstrated from the steady increase of community treatment orders (**CTOs**) in a number of jurisdictions, despite the introduction of a capacity criterion. Recently, Western Australia, South Australia, Queensland and Tasmania have introduced a capacity criterion to their respective mental health legislative schemes. Prior to this, the issue about whether a person had capacity to accept or refuse treatment was not considered. Following the change in legislation, the position is that people should not be subject to compulsory treatment (including in the community with a CTO) if they have capacity.

29 When each jurisdiction introduced a capacity criterion, it could reasonably be expected that there would be a significant drop in the number of CTOs. This is because it would be quite surprising if people were on the one hand, well enough to receive treatment in the community (as distinct from the inpatient setting), but on the other hand, were taken to be so unwell as to lack the capacity to make decisions regarding their own treatment. Conversely, the same drop would not be expected in respect of inpatient orders as you would assume those that are in hospital are the most unwell and may in fact lack decision making capacity. This is my reasonable guess (albeit there is no data on this).

30 The evidence to date is that there has not been the decrease in CTOs that would be expected. Rather, CTOs have kept increasing slowly.[5] In my view, this means that the change in legislation has not transferred through to the coal face or to those 'on the ground'. People are still doing what they did before. Anecdotally, the issue of capacity is not considered as being as relevant as it should be.

Safeguards

31 In my view, the legal advocacy rates in Victoria are shamefully low. In New South Wales, if you have an appearance before the Mental Health Review Tribunal, you will have a legal advocate who will be assigned to you. To my knowledge, that does not always

[4] See: Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2017) 24 *International Journal of Mental Health and Capacity Law* 87; Christopher Maylea and Christopher James Ryan, 'Response to Carroll - President of the Victorian Mental Health Tribunal' (2018) 24 *International Journal of Mental Health and Capacity Law* 10.

[5] See paper in preparation that will likely be published in Australasian Psychiatry later this year. Raw data for this paper is available if desired.

happen in Victoria. Further, in both jurisdictions, there is usually no representation for people at community treatment order hearings, which is really where the issue of capacity should be tested, as people who are in the community are more well than they would have been whilst still an inpatient. I have reviewed approximately 100 decisions in the Victorian Mental Health Tribunal and it appears from that review that the tribunal do not take capacity into consideration.[6]

32 In terms of advance statements in Victoria, my knowledge is limited on this issue. In theory, advance statements are a good idea. However, my impression is that the uptake of these is low. The position in New South Wales is similar in those places where advance directives are used and available. The uptake of these is so low that I cannot really comment on their use. There is also the issue of whether advance statements or advance directives will be followed. In my view, this will only be the case if everything lines up at the right time; unless all 'ducks are in a row', which is to say that people have to take up the advance directive, they must have confidence that it will be given due notice, and clinicians have got to look for advance directives and then to them seriously.

33 I am ambivalent about the utility of advance directives, even when all the ducks line up. There are risks with drafting an advance statement a year before you become unwell, in circumstances where you have no idea what you will be like in that situation. There is quite a lot of wriggle room with ensuring these are followed but in my view there should be. People are not great at knowing what they will want a long way into the future when they are considering what are essentially hypothetical scenarios.[7] For many people with mental illness, the scenarios will not be hypothetical – they will have been through all of this before and in those circumstances, I am less anxious about the utility of advanced directives and am not so keen on the wiggle room inherent in them. These are not straightforwardly useful tools.

Convention on the Rights of Persons with Disabilities

34 There are various interpretations of the *Convention on the Rights of Persons with Disabilities* (**the *Convention***). The question of whether, or to what extent, Victorian legislation is compatible with, the *Convention*, depends on the interpretation of the *Convention* that one adopts. If you take the Committee on the Rights of Persons with Disabilities' interpretation, it is clear that it does not give effect or comply with the

---

[6] See: Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2017) 24 *International Journal of Mental Health and Capacity Law* 87.

[7] For a discussion on this aspect of advance directives at least as they apply to end of life decisions, see: Christopher James Ryan, 'Betting Your Life: An Argument against Certain Advance Directives' (1996) 22 *Journal of Medical Ethics* 95.

Convention.[8] However, I personally do not take that interpretation.[9] Regardless, the problem with the Victorian legislation, at least with respect to the issue of decision-making capacity and it relationship to article 12, is that it is hard to see whether capacity is in the legislation which means that, in effect, it does not give effect to the *Convention* in that regard.

Future state

35 The system should be focused on finding ways of supporting decision making for people with mental illnesses. All the legislative schemes around Australia do that in various ways – however this comes down to how the scheme is applied in practice.

36 In my view, rates of compulsory treatment should be reduced, at least with respect to CTOs. This is particularly so for Victoria which has one of the highest rates of CTOs in the world. There is little data to suggest that CTOs are effective.[10]

37 There should be a better opportunity for therapeutic relationships and easier access to treatment. If both of these are in place, there will be less need for compulsory treatment. There won't be *no* need, but the need will be less.

38 In terms of improving therapeutic relationships, it is a tough sell to convince people that it is in their best interests to take medication (especially as this medication comes with side effects). Clinicians should be given the time and resources to have these conversations with their patients. These conversations should result in the realisation that usually the treatment (even with its side-effects) is better than being unwell. Clinicians shouldn't be taking a shortcut by saying "*We're not even going to discuss it, you're just going to have it*", when consumers are competently refusing the treatment. That would not be permitted in any other area of healthcare, and it should not be happening in mental health.

39 The reason that CTOs might work (if they do, which they probably don't) is not because consumers are compelled to have treatment, but because services are compelled to provide treatment. To the extent that CTOs appear to work in some studies, it only happens where consumers are getting more time from clinicians when they are on CTOs than they do if they are not on CTOs.[11] A lot could be done for people simply by the

---

[8] Committee on the Rights of Persons with Disabilities, Draft General Comment on Article 12 of the Convention - Equal Recognition before the Law (2013).
[9] See: Sascha Callaghan and Christopher J. Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39 *University of New South Wales Law Journal* 596.
[10] See for example: Giles Newton-Howes and Christopher James Ryan, 'The Use of CTOs in Competent Patients Is Not Justified' (2017) 210 *British Journal of Psychiatry* 311.
[11] See for example: Anthony Harris, et al., 'Community Treatment Orders Increase Community Care and Delay Readmission While in Force: Results from a Large Population-Based Study' (2018) 53 *Australian & New Zealand Journal of Psychiatry* 228.

provision of good care, more often. Greater access to care and treatment results in better outcomes for people with mental illnesses.

Collection and publication of data on compulsory treatment

40 Overall in Australia, there is a poverty of data on the use of compulsory treatment.

41 In some jurisdictions, the data is not collected, and in others, it is collected in a way that cannot be easily compared with other data.[12]

42 Without the data, there is no way of knowing whether particular jurisdictions or particular health services are over-using compulsory treatment. Further, without comparative data, there is little incentive to reduce current rates of compulsory treatment.

Best practice use of compulsory treatment

43 In the absence of accurate and reliable data on compulsory treatment, it is difficult to assess which jurisdictions or particular health services are operating at a level of best practice. In my view, if you asked each health service what best practice looked like, they would refer to their own service. Most practitioners consider themselves to be doing a good job. Most of them probably are doing a good job, but they can't all be doing the best possible job, because they are going about it different ways.

Improving culture regarding use of compulsory treatment

44 As I have said above, the key issue with the use of compulsory treatment is not the legislative scheme, but the way in which it is applied in practice. This is in part due to the culture around the use of compulsory treatment, which needs to be improved.

45 While many say it is difficult to change culture, in fact there are not too many people whose views would need to change to make a big difference. The key groups to target would be public hospital trainees in psychiatry and public hospital psychiatrists. If this group are educated on, for example, the doubts surrounding the effectiveness of CTOs, the result would be that there would exist a group of trainees with that mind-set. That can and should impact on the use of compulsive treatment moving forward. My view is that practically speaking, changing culture around compulsory treatment (particularly regarding CTOs) would not be that difficult.

[12] See for example the difficulties in comparing data on CTO usage in Edwina Light, 'Rates of Use of Community Treatment Orders in Australia' (2019) 64 *International Journal of Law and Psychiatry* 83.

Physical design of mental health facilities

46 Mental health facilities should be lovely places to be. They should be the sort of place people want to come and people should feel happy to be there. Currently, many mental health facilities are awful places to be. There is a substantial difference in the appearance and quality of mental health facilities compared to general health facilities. The largest facility in Sydney was built in the 1970s, is not well designed and looks like an old institution. If cardiology patients or chemotherapy patients were admitted to an environment of that sort, there would be an uproar.

47 There is limited evidence to suggest that better looking facilities bear upon treatment efficacy. As far as I am aware, there is no research that compares two units (one beautiful, one less so) with the impact on treatment outcomes. However, there is qualitative research to suggest that people do not think the facilities are very nice. However, in my view, I do not believe we *need* this type of research or data to support the idea that mental health facilities should be beautiful.

48 There is of course a balancing act between not having a risk posed to individuals, and also having beautiful facilities. There are some practical limitations that need to be considered from a design perspective (for example there should be no, or at least as few as possible, ligature points) but there is no reason why mental health wards need to be the way they currently often are.

49 There is evidence that locking doors does not prevent suicide.[13] In New South Wales, I believe there is only one unit that does not have locked doors. All other units have locked doors. In my view, while not all psychiatric units should be unlocked, the idea that we have every unit locked is terrible.

50 In my view, a beautiful environment would also help with avoiding escalation of difficult behaviour. It is important that we set up environments for people where they do not escalate, and therefore do not need to be "deescalated". I am not saying that if you change the environment, no one will ever escalate. Rather, things should be set up so that individuals are less likely to become easily upset or frustrated. In my view, escalation aside, people who are having a terrible time should be in an environment that is really nice.

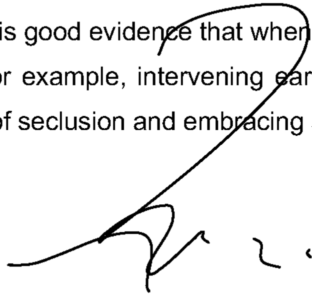
51 More broadly speaking, there is data on how to avoid escalation, in particular with respect to seclusion and restraint.[14] There is a suite of things you can do to reduce escalation,

---

[13] Christian G. Huber, et al., 'Suicide Risk and Absconding in Psychiatric Hospitals with and without Open Door Policies: A 15 Year, Observational Study' (2016) 3 *Lancet Psychiatry* 842.

[14] See for example: A. Putkonen, et al., 'Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men with Schizophrenia' (2013) 64 *Psychiatric Services* 850.

and there is good evidence that when they are done together, it works. These measures include, for example, intervening early, changing staff attitudes and culture, reviewing numbers of seclusion and embracing a non-blame environment.



sign here ►

print name Christopher Ryan

date 21 May 2020