MHLEPQ

MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

shining a light.

Eliminating Coercive Practices in Queensland Mental Health Services

A Mental Health Lived Experience Peak Queensland Discussion Paper
Ailsa Rayner, Cate White, Melissa Pietzner, MHLEPQ staff &
ConNetica Consulting

contents.

acknowledgement of country.

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges and honours the Traditional Owners of the Lands and Waters throughout Queensland. We thank the Elders - past, present, and emerging – for their wisdom and survivorship. We acknowledge that First Nations Peoples have a unique experience of trauma in the mental health system. They have been heavily impacted by coercive practices that involve cumulative and compounded factors such as racism, stigma and discrimination, intergenerational social disadvantage, and marginalisation through ongoing colonisation. We respect First Nations Persons' rights and autonomy to lead their own healing, through their own culture and connectedness to Country, family, and spirit.

recognition of lived experience.

The MHLEPQ would like to recognise people with a lived experience of mental ill-heath and suicidality who have endured the harm caused by coercive practices within a system that was intended to support them. We honour people who have fought for change over many years, including the right to have a collective voice that challenges existing harmful practices and who tirelessly work toward positive change within the systems that have caused harm. We draw upon the lived experience expertise and knowledge of our members to evidence necessary reforms, using organisational values of Safety, Respect, Intentionality, Integrity, and Outcomes.

giving thanks.

The MHLEPQ staff would like to pay our deepest respects to the many people who have contributed to this report in small and large ways, all of them significant to the process. We are especially grateful to the Lived Experience Advisory Group members Ailsa, Cate, and Melissa, who persisted through the challenges from beginning to end and who have each left their incredible mark on the work. Your passion and understanding of the topic were incredible. Thanks also to John Mendoza and Marion Wands for their dedication to the vision of a society free from coercive practice, and sharing their knowledge and evidence base about how to get there. It was John's inspiration that led us to Leonard Cohen's quote, and the naming of this paper, "There is a crack in everything, that's how the light gets in".

concepts & terminology.

We have gathered a comprehensive table of definitions that conceptualise coercive practices through a lived experience lens, based on a literature scan of mental health sector definitions (Appendix 1). We acknowledge the ongoing challenge with the inconsistency of terminology across the sector and how these impact the experiences of care for consumers as well as the difficult implications this creates for legislation, policy, and practice.

We use the term "coercive practices" in preference to "restrictive practices" to include the full spectrum of regulated and unregulated practices in the sector, as identified by people with a lived experience of them. The exception to this is when we are using organisational terminology in the context of their own specific practices – for example hospital-based "seclusion". In that case, we use common shared language while acknowledging that "seclusion" sits as a subset underneath the umbrella term of a coercive practice.

The MHLEPQ has adopted the following descriptions of coercion, coercive practices and combined coercive practices based on consumer, professional and sector insights.

Coercion	Forceful action, involuntary treatment, or threats undertaken while providing treatment or addressing perceived harm that a person poses to his/her own self or others due to a mental health condition (WPA 2022, NMHCCF 2020).
Coercive practices	Include formal detention, treatment without consent ("compulsory treatment"), seclusion and restraint, including the use of mechanical devices, person-to-person restraint, or psychotropic drugs for the primary purpose of controlling movement ("chemical restraint") and / or the use of electroconvulsive treatment.
Combined coercive practices	Used often, where for instance seclusion and restraint are used together, e.g., instances where people are manually or physically restrained to be taken to a seclusion cell or room; and physical and mechanical restraints are used in conjunction with chemical restraint, e.g., when people are forcibly held down (manual restraint) so that they can then be sedated (WHO 2019).
Involuntary treatment	Also called "compulsory treatment" involuntary treatments are constituted by three broad types: Forensic, Inpatient and Community Treatment Orders. Involuntary treatment orders (ITOs) are authorised in mental health legislation for the treatment of people without their consent and can include involuntary medication or other treatments, for example, electro-convulsive therapy.

Seclusion	Isolating an individual away from others by physically restricting the individual's ability to leave a defined space (confinement). It may be done by locking someone in a specific space (e.g., room, shed, cell) or containing them in an area by locking access doors, telling them they are not allowed to move from that area or threatening or implying negative consequences if they do (WHO 2019).
Restrictive practices	Also called: restrictive intervention 'restrictive practices' is an overarching term used to refer to the broader context of confinement, including the ward environment, dynamics, atmosphere and routines, which also includes restrictive interventions (Hui 2017). 'Restrictive interventions' describes measures that intend to control/contain service users beyond the daily norms of their environment and include physical/mechanical/chemical restraint, seclusion, and segregation (Hui 2017). Elements of restrictive practice include Involuntary Treatment (both Involuntary Treatment Orders and Community Treatment Orders), Seclusion, and Restraints (Physical, Mechanical, Chemical, Emotional and Environmental) (NMHCCF 2020)
Physical & mechanical restraint*	Also called "Bodily restraint", these are actions aimed at controlling, restricting or subduing a person's physical movement through forceful methods, including: prolonged or unsafe holding by other people; and the use of any devices such as belts, harnesses and straps to restrict. (WPA 2022, NMHCCF 2022).
Chemical restraint**	Also called "medical", or pharmacological restraint", chemical restraint** occurs when medication that is sedative in effect is prescribed and dispensed to control a person's behaviour rather than provide treatment. Chemical restraint is not a form of treatment. Rather, it is medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition (NMHCCF 2020). The NMHCCF acknowledges that Australian jurisdictions have legislated to remove chemical or pharmacological restraint as an intervention in their MHSs. However, the difficulty in defining chemical restraint remains in the fact that the use of medication to reduce agitation is often considered an acceptable alternative to seclusion and restraint, rather than a form of restraint in itself.

Emotional restraint***

Emotional (or psychological) restraint occurs when the individual consumer is conditioned to such an extent that there is a loss of confidence in being able to express their views openly to clinical staff, without fear of the consequences. Emotional restraint could involve several power-control strategies such as threatening and manipulation, harassment, verbal abuse, bullying and provocation such that people feel forced to comply for fear of reprisals (NMHCCF 2020)

One example is clinicians informing a person experiencing mental health challenges that they are being treated as a voluntary patient and can leave the department when they choose but advising that if they do try to exercise their right, they will be forcibly detained in the emergency department under 'duty of care'[1]

Environmental restraint****

Restriction of a person's free access to all parts of their environment, including items or activities. Environmental restraint refers to restricted access to a room or part of a person's own home which can include: locked cupboards or fridges; not being able to access one's own possessions without permission; rooms that are locked and can't be accessed without permission; being denied visitors and not being able to access the community (NMHCCF 2020)[2]

Systems Approach

An innovative approach that optimises the outcomes of any system by considering all inter-connected parts of the whole, and the way these parts interact to enable better functioning or to create barriers. Understanding and enhancing function of every element, and how multiple elements interact, provides more cohesive and integrated system outcomes.[3]

* Bodily restraints must only be performed within a legal framework for patients under the Mental Health Act, and only as a last resort when the use of less restrictive and reasonable options have been considered or attempted. If an individual is not being treated under the Act, the use of bodily force must only be carried out for the sincere belief that serious imminent harm to the person being restrained, or another person will be prevented, and the harm inflicted must be less than the harm sought to be avoided. This means the use of these bodily restraints in this setting and acute mental health settings alike, must be of absolute and unwavering necessity. In the absence of legitimate necessity and the backing of a legal framework, the use of physical and mechanical restraints is by definition, assault.

** The NMHCCF acknowledges that Australian jurisdictions have legislated to remove chemical or pharmacological restraint as an intervention in their MHSs. However, the difficulty in defining chemical restraint remains in the fact that the use of medication to reduce agitation is often considered an acceptable alternative to seclusion and restraint, rather than a form of restraint in and of itself.

*** Psychological and chemical restraints are traumatising, counter-therapeutic, unethical, and inexcusably unregulated.[4]

**** Environmental restraint is worthwhile considering in the mental health sector as there are many instances in Queensland, for example, due to the Locked Wards policy directive, that people are environmentally restrained as voluntary patients due to being locked into a ward and not being able to independently leave and return. Environmental restraint isn't regulated in mental health services, and as such can impinge on the dignity and human rights of people with psychosocial disability if implemented, but not monitored or recorded.

key messages.

1. Momentum is gathering in Queensland and across Australia for a systemic approach to eliminating coercive practices in all care settings. This discussion paper represents the MHLEPQ members' collective views on coercive practices within the Queensland mental health system. The paper also draws on state, national and international evidence bases, in consultation with our members.

2. We are guided by the following lived experience principles about the use of coercive practices:

- They are systemic failures of care that cause harm to people subjected to them, people applying them, and people witnessing them.

- Their use breaches domestic and international human rights laws including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

- They cause moral injury and psychological distress for staff and represent a workplace health and safety hazard.

- Professional ethical standards are compromised when applied in non-evidence based, non-therapeutic and non-regulated ways.

- Their systemic misuse indicates poor organisational culture.

- Elimination can be achieved through the implementation of recovery-oriented care based on individual human rights frameworks.

3. Any use of coercive practice within the mental health system is traumatising and infringes on individual human rights, autonomy, and dignity. Coercive practices cause harm and should therefore be eliminated, and alternative settings, practices and therapies used. Any use of coercive practices must:

- Allow the greatest consumer autonomy through supported decision-making.

- Be comprehensively documented against a framework based on international human rights conventions and relevant domestic legislation (including the UNCRPD).

- Require an investigation that details organisational accountability and identifies the person authorising the coercive practice, based on restorative justice principles and methods.

- Ensure full disclosure of incident documentation with the person subjected to the coercive practice (and / or their carers and advocate).

- Provide documentation that is available for review and reporting by lived experience auditors.

4. A consumer-led, community-based, and person-led mental health system that upholds individual human rights is widely advocated for, and there are an evidence-base for these in Australia and overseas.

5. Consistent statewide data management and reporting on all use of coercive practices in Queensland Health managed and contracted services, is required.

6. Principles to reform and eliminate the use of coercive practices involve:

- Whole-of-system reform to minimise the system-related harm experienced by consumers during every part of their recovery.

- Lived experience leadership and participation at all stages of priority setting, healthcare system design and service delivery and continuous quality improvement.

- Organisational and professional cultural improvements that use person-led philosophies, values and principles that uphold people's human rightsin policy and service delivery.

- Culturally safe and trauma-informed policies and practices at the service level that align to restorative justice principles.

- Lived experience-led development of data governance and sovereignty, including privacy principles, record-keeping and access and equity.

- Collating comprehensive and integrated data including lived experience data that informs safety, quality improvement processes.

- Resourcing lived experience workforce development, including access to effective and evaluated least restrictive models of practice.

7. State responses to the harm of being subjected to coercive practices within the mental health system are crucial to personal healing. For people who have been harmed, lived experience-led restorative justice principles must underpin:

    - State and system

acknowledgement of harm

- Truth and reconciliation processes
- Individual reparations
- Collective reparations
- Symbolic reparations, and
- A committment to not repeating harm.

This discussion paper[5] represents lived experience evidence and perspectives from multiple sources. It contains common terminology associated with coercive practice; discusses findings from the evidence base; and makes recommendations for changes necessary to improve the experience of people seeking mental health care and support, including alternatives to coercive practice.[6] The recommendations provide a basis for a campaign strategy to advocate for the elimination of coercive practices within the Queensland mental health system.

recommendations.

Levers for change, sustained implementation, and evaluation of alternatives to coercive practices must be designed in consideration of individual, community, sectoral, governmental, and whole-of-society factors. This section makes recommendations and strategic calls for action relating to human rights instruments, coercive practice legislation, policy, and practice guidelines, and restorative justice, including responsibilities at various levels of the sector.

COMMONWEALTH GOVERNMENT

1. That the Commonwealth Government ensure compliance with the OPCAT to allow the United Nations Subcommittee on the Prevention of Torture to carry out its mandated unrestricted access to Queensland mental health places of detention, and where required pass Commonwealth legislation under the International Conventions' power to support this.

2. That the Commonwealth Government request the Australian Human Rights Commission to report on Australian compliance with human rights obligations under relevant treaties, including but not limited to the UNCRPD and OPCAT, as they apply to the use of coercive practices in the mental health systems across Australia.

3. That the Australian Human Rights Commission is expanded to include an eighth Commissioner with specific responsibility for mental health, mental illness, and suicidality.

4. That the Federal Parliament enact legislation to enable National Mental Health Commission status as an independent, statutory authority. Legislative inclusions should allow requests for information from Australian, State and Territory Government agencies. [7]

5. That the Federal Parliament enact legislation requiring state and territory jurisdictions to report consistently to the National Mental Health Commission with coercive practice data from across the health system.

6. That the sixth National Mental Health and Suicide Prevention Plan recommends to state and territory jurisdictions to prioritise those actions from Priority Area 4 of the 5th plan for improving Aboriginal and Torres Strait Islander mental health, either not commenced, or not on track.

7. That the Commonwealth Government implements a Mental Health Stigma and Discrimination Elimination policy with specific focus on eliminating stigma and discrimination within the health and social systems.

QUEENSLAND GOVERNMENT

8. That the Minister request a report from the Queensland Human Rights Commission on the human rights implications of the use of coercive practices as they're currently applied by Hospital and Health Services and provides recommendations where necessary.

9. The Minister requests that the QMHC provides an annual report

card to the Parliament on the implementation of the recommendations from the Government's response to the Queensland Mental Health Inquiry recommendations, against the framework of Shifting Minds.

10. That the Minister and Government follow the recommendations from the Victorian Not Before Time report and formally undertake a Truth and Reconciliation process informed by culturally safe restorative justice principles, followed by a formal state apology to consumers, carers and families harmed by the mental health system.

11. That Queensland Health prioritise organisational and service culture development according to Priority 4 of Better Care Together and monitor and reports biannually on progress against recovery-oriented, person-led, culturally safe, trauma-informed and human rights-based indicators.

12. That Queensland Government establishes and resources the office of Chief Lived Experience Officer. The Office of the Chief Lived Experience Officer will be the Queensland Government's principal advisor on all matters relating to peer-work, collaboration and co-design with people of lived experience at all levels of policymaking, organisational design, governance, and service priority-setting with a particular authority and expertise in advancing, leading and advising on matters that promote a person centred approach to mental health services in Queensland.

13. That the Chief Lived Experience Officer leads systems reform and integration of the lived experience (peer) workforce, including achieving the target of 10% identified lived experience (peer) workers.

14. That lived experience (peer) auditors will have a central role in investigating, reporting, and making recommendations about systemic human and patient rights breaches, including the power to visit and spot check on mental health units.

15. That the Chief Psychiatrist conducts a review of all Queensland mandatory policies under the Mental Health Act against the Queensland Human Rights Act.

16. An independent review of the practical application of the Mental Health Act according to Australia's existing obligations under the UNCRPD (2006) should be undertaken by a Minister-appointed Commissioner, such as the Human Rights Commissioner or the Mental Health Commissioner.

17. That Queensland Health develops and implements a policy directive and strategic plan for monitoring the elimination of coercive practices. Where people are subjected to

coercive practice, processes must be comprehensively documented against a framework of individual human rights according to the Convention on the Rights of Persons with Disabilities, supported decision-making and informed consent. The person authorising coercive practice should be identifiable and fully accountable for the decision in accordance with restorative justice principles.

18. That the Chief Psychiatrist abolish the locked wards directive as a matter of urgency. Admission to a locked ward should be a last resort and only be where a specific assessment of the individual's unique circumstances are fully considered. Use of locked wards should be limited to individuals under specific court orders requiring such admission or assessed as being required to enter a psychiatric intensive care unit.

19. That Queensland Health ensures that all mental health facilities that have a locked ward also have an open ward to ensure facilities are available to provide care in a person-led manner, and according to [s18(2)] that there is no less restrictive way for the person to receive treatment and care for the person's mental illness.

20. That Queensland Health develops a safety and quality improvement framework requiring all instances of coercive practices to be investigated as failures of care, using restorative justice principles.

21. That Queensland Health develops data and information sharing policies where a person (or their authorised advocate) who has been exposed to coercive practices have automatic rights to all records, journals and notes relating to the person's care.

22. That Queensland Health publicises biannual data relevant to the use of coercive practices across the health system, including that involving contracted service providers. Data should be guided by equity principles that analyse the use of coercive practices according to social disadvantage, ethnicity, region, diagnoses, and other marginalised identities.

23. That Queensland Health develops a statewide policy for informed consent and supported decision-making with direct reference to coercive practices, including consent by advance health directives and by an authorised guardian or advocate.

24. That Queensland Health prohibits the construction of new seclusion facilities and develops plans to decommission existing seclusion facilities.

25. That all Hospital and Health Services develop and implement plans for alternative pathways to and settings for care that reduce crisis presentations and agitation. These should form part of a whole-of-system approach to reform.

introduction.

The Mental Health Lived Experience Peak Queensland (MHLEPQ) is funded by the Queensland Government to provide a collective voice for advocacy and systems reform of the Queensland mental health system. We have also been established to support and develop consumer advocates to contribute to mental health committees and boards and lead the reform agenda.

In our submission to the Parliamentary Select Committee Inquiry into the Mental Health of Queenslanders in 2022, we described consumer perspectives about key areas for reform, including structural issues of power imbalances, cultural blindness, and a failure to consider the social determinants of mental health. People with lived experience of the mental health system spoke about the prominent issue of coercive practices that did not meet their person-led needs, and worse, exacerbated their existing distress:

> *"I experienced restraint, confinement, and coercive control. These experiences often led to more trauma, unbelievable debilitating side effects and loss of quality of life."*[8]

At the beginning of 2023, MHLEPQ began a lived experience-informed project advocating for the elimination of coercive practices within Queensland Health mental health services. The first phase included consultation with Queensland Health (QH) on their draft Restrictive Practices Position Statement, followed by a broader piece of work in consultation with our members, with the aim of developing a position statement on coercive practices.

We took a systems approach, considering coercive practices from the perspective of people who have direct experience of them. Qualitative and quantitative data were gathered from broad sources and across multiple knowledge sets, including:

1. The Lived Experience Advisory Group's (LEAG) Statement of Advice to Queensland Health, which informed the development of the Department's position statement on restrictive practices.

2. An external scoping review of the publicly available data on restrictive practices in mental health services in Australia, focusing on Queensland.

3. Academic and grey literature on the topic of coercion in the mental health and social sectors, with a focus on lived experience evidence.

We consulted MHLEPQ members on the draft discussion paper gathering lived experience knowledge of coercive practices (both regulated and unregulated). We heard from members between the ages of 27 and 68 who identify as First Nations, LGBTQIA+, living with disability and neurodiversity. All survey participants were based in Brisbane, Queensland, a gap in representation that the peak will seek to strengthen in the future by active engagement with people who live in more geographically diverse areas.

findings.

Coercive practices cause harm and breach consumer human rights across the scope of mental health service provision, often preventing people from seeking care.

> *Restrictive interventions are not therapeutic. They are intrusive practices used as a last resort to prevent serious and imminent harm to a consumer or another person. In Victoria, the Department of Health, the Chief Psychiatrist and public mental health services have undertaken a number of activities to promote the reduction of restrictive interventions. Restrictive interventions should only be used after all possible preventative practices have been tried or considered and have been found to be unsuitable. The use of restrictive interventions has been linked to re-traumatisation of past experiences, serious injuries and even death.*[9]

Coercive practice occurs for erroneous reasons including behaviour management, punishment, the service environment and inappropriate resourcing. People who have both voluntarily and involuntarily accessed mental health services may be subject to coercive practices, which are also reported to occur outside of the context of authorised mental health services and the Mental Health Act (2016) (referred to as The Act).

Goals of clinical recovery continue to be privileged over personal recovery, especially with respect to medication. A consumer's desire to decrease or stop medication is often framed as 'non-compliance', or evidence of mental illness.

Some people are more likely to be subjected to coercion than others. First Nations people experience higher rates of hospital seclusion and restraint when compared with non-First Nations people[10], as do other marginalised, disadvantaged and minority communities, certain age groups and non-Australian citizens. [11] Evidence also shows people with mental health diagnoses such as Borderline Personality Disorder being increasingly coerced with stigmatising labels such as "difficult patient".

Coercive practice is challenging to eliminate, partly because of societal and media representation that reinforces stigma, discrimination, and fear of people with severe mental ill-health:

> *"Mental health professionals, policy-makers and media outlets [need to work] together to reduce stigma and discrimination against people with mental ill health. Stigma feeds misguided perceptions that widespread use of coercive mental health practices is necessary to public safety, and places undue pressure on service providers to overuse coercive practices."* [12]

A consumer-led, community-based mental health system has been widely advocated since the First National Mental Health Plan in 1993; one that has a broad focus on holistic wellbeing, supports and accommodates the choices of the consumer, and meets human needs according to people's cultural and identity requirements. [13] The current evidence base challenges the assumption that coercive practices are inevitable and makes a call to action to provide culturally safe, trauma-informed, and compassionate approaches to mental health service design and practice. Findings from people with lived experience and the literature on coercive practices are described and discussed in the following sections.

OUR GUIDING PRINCIPLES

We are guided by principles and contemporary standards about the use of any coercive practice in the health and social sectors, aligned with many of those expressed by those with lived experience and consumer organisations.

Coercive practice:

- **is a systemic failure of care** that causes harm to people subjected to them, people applying them, and people witnessing them.
- **breaches individual human rights**, and their use is contrary to domestic law and international conventions and instruments such as the United Nations Convention on the Rights of People with Disability (UNCRPD).
- **causes moral injury and psychological distress** for staff, representing a workplace health and safety hazard.
- **compromises professional ethical standards** when applied in non-evidence based, non-therapeutic and non-regulated ways.
- **represents poor organisational culture** that enables systemic misuse of non-therapeutic practices.
- **can be eliminated**, or at the very least reduced to exceptional circumstances. This requires a redistribution of power between consumers, their families, practitioners, and within mental health systems. The implementation of recovery-oriented alternatives is required.

LEADING WITH LIVED EXPERIENCE

Lived expertise and community-led approaches to systemic change needs to be applied at multiple points, including in political, legislative, policy and professional arenas. People with lived and living experience of coercive practices in mental health service settings are perfectly positioned to inform the sector about what needs to change.

> *"Researchers should engage mental health service users and their families and carers, as people with lived experience bring insight that is crucial to successful development and evaluation of non-coercive mental health care."* [14]

The National Mental Health Commission (NMHC) noted in 2020 that "beyond inclusion, mental health reform needs to place those with lived experience at the centre, as the driving influence for change and system improvements." [15] The Royal Australian and New Zealand College of Psychiatrists (RANZCP) also recommended that governments and mental health service organisations work towards minimising and eliminating seclusion and restraint practices and "Ensure people with lived experience of mental health conditions are involved in designing policies, frameworks and spaces for best methods to minimise the use of seclusion and restraint in mental health services". [16]

Through a lived experience lens, we know that some of the root causes of the system-related harm people have experienced can be found in power imbalances, lack of cultural safety, and social determinants that exist upstream of the crises people may find themselves in. In their submission to Queensland's Select Committee Inquiry, the MHLEPQ recommended addressing power relations through co-design with lived experience representatives. [17]

> *"Lived experience is key to both defining the problems to be solved and developing solutions. Issues of power imbalances must specifically be considered in the establishment of any co-leadership processes."*

Consumer knowledge also describes the importance of lived experience (peer) workforces to the wellbeing of people with mental ill-health or distress, and the need to focus on intersectionality associated with ethnicity; gender; sexuality; class; disability status; socioeconomic disadvantage; housing and employment status; and co-morbidities such as drug and alcohol misuse, serious mental illness and poor physical health.

ORGANISATIONAL & PROFESSIONAL CULTURE

> *[…] the most contentious aspect of contemporary psychiatry is its continuing reliance on coercion as part of clinical care, a legacy of its institutional history. Although the large majority who come in contact with mental health services do not experience coercive care, involuntary detention and forcible treatment are universal experiences in mental health services. Such involuntary treatment is often associated with the use of force, such as seclusion, restraint and forcible treatment. These coercive practices are legitimised, approved and routinely employed as part of mental healthcare in rich and poorer countries and in hospitals and community settings.* [18]

Consumers spoke to the MHLEPQ about owning their identity in a way that is free of the mental health systems' judgements about who they are, what they need, and what they are capable of. People have the right to autonomy, dignity, and meaningful partnership in their recovery journeys, free of system-related harm by destructive practices that are known to work against consumer-led recovery:

> *I find it interesting the way that restrictive and coercive treatment impact on the ongoing relationship with access to and experience of care. Due to the restrictive and coercive treatment inherent in care in the public sector - it genuinely took me over 15 years before I learned that care didn't need to be combative! It wasn't until I was given dignity of risk and grace to fall within the system that I learnt to be a partner in care. The system sets us (consumers and workers) up for greater restrictive practice. It takes a lot of unlearning to have a healthy relationship with the healthcare setting.* [19]

Organisational culture is a strong predictor of service safety and the capacity of institutions to learn and change. The ideology that underpins mental health institutions and professions is important to examine for their sites of power. Power differentials at various levels and points of the system are known causes of inequity and are often cited as a reason for failed improvement within the mental health sector.

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Current mental healthcare philosophy, legislation, policy, and practice remain informed by a historic psychiatric legacy that supports coercive practice. [20] [21] Leadership is fundamental to changing the experience of care, by understanding organisational and professional culture, models of care, and staff attitudes and behaviours toward mental health service consumers. [22] Relevant perspectives include:

1. Clinicians hold power and legitimacy through legal and medical means, able to determine what's best for the consumer (sometimes against the consumer's wishes).

> *"Recent emphasis on the right to autonomy involves questioning the legitimacy of the paternalistic attitude that used to be the norm in medical care. Patient's best interests are increasingly taken as critical elements for deciding upon or justifying coercive measures [...] The risk of abuse of power associated with paternalism is now taken seriously."* [23]

2. Evaluations of a person's decision-making capacity while subjective, arbitrary, inconsistent, and known to be deleterious to recovery, continue to be seen as "objective" and legitimised through a professional-centric lens. [24]

3. Biomedical risk assessment is often over-prioritised, with researchers pointing to the increasing misuse of "duty of care" to justify coercive practice. [25]

> *"If one person has more power than any other person, the more powerful person can exert their will over the less powerful one in often harmful or patronising ways. Therefore, personal empowerment is the key to reducing vulnerability and thus the primary construct informing our duty of care."* [26]

4. Imbalances of power enable the practices of minimising the importance to the consumer of the "dignity of risk", whilst overinflating "safeguarding" and "duty of care" as rationale for coercion:

> *A more sophisticated approach considers the dignity of risk as a fundamental principle or practice of our duty of care in the first place. That is by empowering our customers to take risks in exercising choice and control, we are making them safer by that very act of empowerment.*

> *The dignity of risk is, in itself, a duty of care. This is because the primary consideration in safeguarding is the reduction of a customer's vulnerability by enhancing their ability to safeguard themselves. Vulnerability is defined by an imbalance of power.* [27]

5. Issues of fault: consumers are labelled and blamed for their condition, for example, "difficult patient" and viewed in isolation from their context and/or genetic disposition/risk. Overused labels such as "manipulative" are used by clinicians to legitimise the refusal of service, denial of care or inappropriate referral or discharge. Discriminatory labelling is more likely with certain diagnoses such as borderline personality disorder. [28]

6. The capacity of the State to detain people that they determine to be mentally incapacitated and unfit to stand trial, indefinitely or for extended periods, has been highlighted as an area of human rights concern. [29] [30]

7. A sociocultural factor identified by one MHLEPQ member that contributes to stigmatisation and harm for people with lived experience includes the "state capture of our institutions by commercial interests, which has led us down the road of labelling and coercion" . [31]

HUMAN RIGHTS PERSPECTIVES

In Australia, multiple inquiries, reviews, and reports have described the human rights breaches that act as a barrier to supported decision-making and fully informed consent in the lives of people living with mental illness and who experience mental distress for which they seek support. [32] Deinstitutionalisation and supported decision-making frameworks, as recommended by proponents such as the Australian Law Reform Commission (ALRC) [33] and the Committee on the Rights of Persons with Disabilities, will go a long way to upholding the human rights to *equality and non-discrimination, equal recognition before the law and liberty and security of person.* [34]

Australia has obligations to international human rights conventions and instruments that relate to mental health and psychosocial disability including, but not limited to: [35]

1. UN Convention on the Rights of Persons with Disabilities 2006

    - The right for people with disabilities to enjoy the highest attainable standard of health, without discrimination based on their disability [36]

    - The right to equal recognition before the law (Article 12) and the right to liberty and security of person on an equal basis with others (Article 14)

    - Freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15) and from exploitation, violence and abuse (Article 16)

    - The right to live independently and be included in the community (Article 19).

    - The right to an adequate standard of living (Article 28)

2. Optional Protocol to the Convention against Torture (OPCAT), ratified in 2017.

3. United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

4. International Covenant on Civil and Political Rights

5. International Covenant on Economic, Social and Cultural Rights (Article 12)

In addition, the Queensland Human Rights Act (section 28) provides that First Nations Australians are not to be denied the right to their cultural heritage, including traditional knowledge and spiritual practices.

While signing the UNCRPD made it obligatory for Australia to amend domestic legislation and develop frameworks sufficient for its implementation and maintenance, enforcement of breaches of these obligations is problematic. [37] Australia's compliance with the UNCRPD is poor and there has been little improvement in the past decade. [38] [39]

Notwithstanding the past domestic indifference to the international conventions, pressure on psychiatry and other mental health groups is building from within the professions to focus on embedding international human

rights conventions into domestic legal contexts.[40] This pressure for reform is also coming from various public inquiries including the national Royal Commissions on Aged Care and Disability and the Victorian Mental Health Royal Commission.

Of note was the October 2022 suspension and later cancellation of the UN Subcommittee on the Prevention of Torture (SPT) visit to places of detention, due to the assessment of obstructive governmental behaviours in Queensland and NSW. [41] The Commonwealth and all other state and territory governments, had assured unfettered access for inspection. The head of the delegation, Aisha Shujune Muhammad reported that:

> *"This is a clear breach by Australia of its obligations under OPCAT. State parties have an obligation to both receive the SPT in their territory and allow it to exercise its mandate in full, as reflected in Articles 12 and 14 […] it is concerning that four years after it ratified the Optional Protocol, Australia appears to have done little to ensure consistent implementation of OPCAT obligations across the country, including but not limited to passing overarching legislation to translate its international obligations into domestic law."* [42]

Human Rights Commissioner Lorraine Finlay said that the UN may consider placing Australia on its Article 17 non-compliance list, along with other countries with significant human rights concerns.

The MHLEPQ note that the AHRC currently has seven Commissioners specific to areas of identified need such as the Aboriginal and Torres Strait Islander Social Justice Commissioner; Children's Commissioner; and the Disability Discrimination Commissioner. Given that there has been an increased national focus on the human right to mental health of Australians, **we advocate strongly for a Mental Health Commissioner to sit within the AHRC.** As seen with the recent appointment of a Minister for Mental Health in Queensland, the trend is toward a specific focus on mental health, alcohol and other drugs and suicide prevention, outside of the direct jurisdiction of health.

THE IMPORTANCE OF DATA

Data collection on coercive practices is globally and nationally inconsistent, which is a major barrier to reform and change.[43] Despite legal and ethical arguments for the use of coercive practices, there is no evidence for their therapeutic value. In fact, the majority of evidence describes the harm to people who are subjected to coercive practices, undermining any legal or ethical arguments for their continued use in mental health.[44] The nature and extent of regulated sanctions such as involuntary admission, often relied on as a proxy measure of coercive care, is unreliably measured, monitored, and reported.

> *"Coercion in its various guises is embedded in mental healthcare. There is very little research in this area and the absence of systematic and routinely collected data is a major barrier to research as well as understanding the nature of coercion and attempts to address this problem."*[45]

Systematic information on various other forms of coercive practices, such as the use of seclusion, forcible segregation, and treatment, is more difficult to access and is often difficult to interpret and compare.[46] In addition, national or state data on the use of coercive practices in emergency departments is not recorded or reported. While the reported seclusion events and mechanical restraint rates have almost halved in Australia over the previous decade, physical restraint events have increased over 10% in the past 5 years.

There are important social, legal, and human rights implications for the development of digital systems that respond to and capture data on psychiatric interventions and state-authorised (regulated) coercive measures.

> *"The implications of these specific power dynamics as well as potential biases in mental health systems must be considered for the ethical development and implementation of any data-driven technology in mental health."*[47]

The possibilities for supportive digital responses and lived-experience data systems are acknowledged, in the context of extreme caution about the possibilities for unintended harm for the people most affected. An analysis of the relationships between technology, data, money, and power – the politics of data governance - must be examined in detail so that their application does not further increase inequality and marginalisation of mental health consumers:

> *Sharing benefits requires that the public and social value of data is directed toward the determinants of human flourishing and good mental health: equitable economic development, directing support where it is needed most, addressing discriminatory practices and histories of exclusion and marginalisation, improving the quality of care and service provision, and other measures known to boost societal wellbeing.* [48]

Inequitable data management, including who owns, oversees and has access to these data, and the consistency and transparency of its reporting are most impactful for people who experience multiple and intersecting disadvantages and social exclusion. [49]

> *Across Australia, data systems and collection practices for adequately capturing information on trans, gender diverse and non-binary people – and our health and wellbeing – are not currently fit for purpose. From the census itself, through to health and demographic data at population-wide and individual levels, we lack appropriate methods for ensuring we are counted; which makes analysing and meeting our needs as mental health system users very challenging.*[50]

Issues surrounding data governance and sovereignty (the right of people to determine, control and protect the data that relates to them) is of particular concern for First Nations and lived experience people. Self-determination can only be realised through working in partnerships that are empowering for the most impacted communities.

A strong evidence base describes the global overuse of coercive practice in mental healthcare, particularly in inpatient settings.[51] In Australia, coercive practice data is incompletely and inconsistently collected, not routinely publicly reported, and often reliant on researchers to publish significant findings.

Of concern is the inability of Queensland's current information technology infrastructure to support data 'interoperability', which should enable data held in different formats and locations to be used together. [52] The capacity to exchange high-quality data between care systems and providers is crucial to consumer outcomes through the capacity to merge accurate information from multiple trusted sources. Interoperability is essential for more connected health services and continuity of care for its consumers.

Where data is reported, it is often aggregated to a level that makes it impossible to discern which groups of people are more likely to receive coercive treatment. The Queensland Office of the Chief Psychiatrist Annual Reports, for example,

report on The Act by Authorised Mental Health Service location, but not by the characteristics of the person receiving the treatment. It is impossible to tell which people by age groups, ethnicities or other identifiers are most impacted.

In Victoria, First Nations people are subject to coercive practices at higher rates than other groups of people. While institutional racism has been identified as contributing to this, there are likely to be complex factors involved, but there is little research that explains why:

> *"Many Aboriginal people have complex trauma. We are concerned with this data and would like to know more on the reasons that drive this overrepresentation. A model of care that is focused on healing, social and emotional wellbeing and cultural safety is what works for Aboriginal people."* [53]

Lack of transparency in public reporting of coercive practice data is a barrier to safety and quality improvement, including full accountability of mental health services for harm caused to consumers. The final report from the Royal Commission into Victoria's Mental Health System provided definitive guidance on data transparency:

> *"[…] publishing meaningful and timely data is vital for transparency, which is a foundational principle of good governance and important for community confidence in all public services."* [54]

Evaluation of legislation and quality improvement strategies that impact mental health consumers remains crucial for identifying gaps and monitoring trends in both 'unintended consequences' and 'outlier' patterns. Assumptions about the value of various practices are often proved incorrect when the data is analysed. Examples from different contexts include:

Recent Norwegian research findings on the topic of the validity of mental health laws:

> *"The assumption that involuntary care protects patients from negative outcomes is not supported by our findings, but neither can it be ruled out […] this raises the concern that involuntary care may not work entirely as intended by lawmakers and clinicians […] Given the concerns voiced by user organizations, the ethical concern surrounding the provision of treatment without a person's consent, and over geographical variations in such treatment, there is an urgent need for additional studies that test core assumptions of mental health acts."* [55]

Unexpected findings from New Zealand's Zero Seclusion quality improvement project such as increased staff retention and fewer incidents of violence toward both staff and consumers. One unit recorded a 30% reduction in assaults on staff, and a 50% reduction in assaults causing harm.[56]

> *"When we care, the violence goes down […] Putting the person at the centre makes the world of difference for them and the staff […] People asked whether other safety measures would be compromised to achieve this reduction [in seclusion], but they have seen it work over time, and the violence drop."*[57]

QUEENSLAND INSIGHTS

The Queensland Act is the legislative and regulatory framework for most of the involuntary treatment, seclusion, restraint, care, and protection of people who are deemed not to have the capacity to consent to be treated. It is the administered by the Chief Psychiatrist.

In 2013 the then newly elected Liberal National Party Government commenced a review of the Mental Health Act (2000). The review and community consultations were continued by the Labor Government elected in 2016.

> *"The principal intent of Queensland's Mental Health Act, when revised in 2016, was to improve the human rights protections afforded to people receiving mental health assessments, treatment, and care under the Act, as well as limiting the number of people subject to compulsory or involuntary treatment."*[58]

The Act has three categories of compulsory treatment orders – Forensic Order (FO), Treatment Support Order (TSO) and Treatment Authority (TA). Patients who have been diverted from the criminal justice system before trial because of unsoundness of mind or unfitness for trial due to a mental illness may be managed under a FO or a TSO. These orders are initiated by a specially constituted mental health court, presided over by a judge assisted by two psychiatrists.

Most people subject to compulsory treatment are not involved with the criminal justice system. For these patients, a TA is used when a psychiatrist determines that: the person has a mental illness, lacks capacity to consent to treatment, and is at imminent risk of harming themself or others; or is at risk of serious mental or physical deterioration in the absence of involuntary treatment. People seeking mental health services may also 'choose' the compulsory treatment pathway as a method to expedite access to 'treatment' in the context of long waitlists.

It is widely recognised that people involved with the mental health system require increased access to legal and non-legal support. One MHLEPQ survey respondent stated that:

> *"The lack of legal representation, recourse and redress currently available to victims [of coercive practices] is a disgrace."*[59]

The *2020 Productivity Commission Inquiry Report into Mental Health* noted the urgent consumer need for improved legal representation and advocacy services, a key deliverable that was benchmarked in 2021 as a key priority under Better Care Together.

Each type of order can be in place during inpatient or community episodes of care. All are subject to periodic review (every six or twelve months) by a Mental Health Review Tribunal (MHRT) comprising a psychiatrist, a lawyer, and an appointed community member. A TA can be revoked by the treating psychiatrist, whereas an FO or TSO can only be revoked by the MHRT.

> *"The Act was seen as a positive development with better human rights protections, intended to minimise coercion in mental health care by including a variety of procedures that were less restrictive than compulsory/involuntary psychiatric treatment in inpatient units and in the community. However, recent evidence indicates that rates of compulsory treatment have increased in Queensland after the MHA 2016 was implemented."*[60]

The 2016 Act was intended to improve the human rights of patients, including by minimising compulsory treatment. It states, *"the main objects (of this Act) are to be achieved in a way that safeguards the rights of persons and is least restrictive of rights and liberties of a person who has a mental illness".* [61]

Findings from limited qualitative data provided some understanding of why the changes in legislation resulted in increased compulsory treatment - the opposite of the *intended* effect.

Giuntoli and colleagues[62] interviewed consumers, carers, advocates, and clinicians on their *experiences* of care following the changes to the Act. They reported that while all parties had positive responses to the intended effects of the legislative changes, their experiences were not consistent with significant changes in service practice or patient outcomes. The reasons included a range of barriers to implementation – culture, lack of relevant expertise and training, and a lack of safeguards in the legislation.

Gill suggested further possible reasons behind this unintended consequence:[63]

1. A paternalistic and restrictive culture in Queensland mental health services.

2. Lack of well-resourced and systematised voluntary alternatives to compulsory treatment.

3. Risk aversion among both clinicians and society.

4. Insufficient legislative reform processes that did not go far enough to lever the quest for change.

5. An increase in the prevalence of illicit drugs such as ice (methamphetamine), which led to both rising rates of drug-induced psychiatric disorders and their severity, and possibly contributing to an increase in involuntary treatment rates; and

6. The Act is limited in its continuing focus on involuntary treatment provisions, with little emphasis on ensuring access to mental health services or promoting the economic, social, and cultural rights of people with mental disabilities.

The Chief Psychiatrist makes policies and practice guidelines under The Act that include seclusion and restraint, which at the conceptual level have been assessed as compatible with the *Human Rights Act 2019*. Our members report that there is a large gap between the guidelines and how they are applied to practice within the Health and Hospital Services which are responsible for their local application. Further, it is unlikely that the locked ward directive upholds Australia's international human rights obligations, even if it meets the *Queensland Human Rights Act.* The discrepancies between guidelines and practice, as well as local and international human rights legislation, need to be addressed as a matter of urgency.

The *Queensland Mental Health Commission Act 2013* legislates the Queensland Mental Health Commission (QMHC) as a statutory body with a pivotal role in reforming the mental health and alcohol and other drug (AOD) systems. They drive change through strategic planning, research, promotion, and engagement activities across Queensland that include, but are not limited to, frameworks such as: *Shifting Minds; Every Life*: *The Queensland Suicide Prevention Plan 2019-2029;* and the *Queensland Framework for the Development of the Mental Health Lived Experience Workforce.*

The *Queensland Locked Wards Directive Policy* is one form of environmental restraint that breaches individual human rights, most notably the UNCRPD and OPCAT. There has been strong criticism about this directive that was introduced in Queensland's acute adult mental health care facilities in 2013, and calls for reform to a less restrictive, more recovery-oriented policy ever since. [64] Professor Gill notes that:

> *"A blanket directive to treat all psychiatric inpatients in a locked environment without individualised consideration of safety is inconsistent with least restrictive recovery-oriented care… It is also contrary to the main principles of the Act (Qld 2016). [65]"*

The use of locked wards positions them as a "place of detention" (along with prisons, juvenile detention centres, immigration detention centres, hospitals, mental health facilities, aged care facilities and facilities for people with disabilities), which is discriminatory, and based on an (often) moral judgement of people being a "danger to others". While there has been a 2021 trial of discretionary locking within a Gold Coast short-stay acute adult inpatient unit, international evidence has already shown that locked wards don't reduce 'absconding', the purpose of the directive in the first place, and are inconsistent with recovery-oriented, least restrictive practices. [66]

The state plan released in October 2022, Better Care Together, includes under Priority 4, "continuing to promote treatment through a least restrictive way and reduce the use of restrictive practices such as seclusion and restraint, and involuntary treatment". Concerningly, there is no indication of timelines, targets, or funding commitments against each of the priority area key actions, and little reliable data to benchmark and measure progress against. Nor is there any acknowledgement that rates of all forms of involuntary treatment and practice have significantly increased in the past decade. In addition, despite the spoken commitment to reducing the use of seclusion, seclusion facilities are still being commissioned and built.

QUEENSLAND DATA

Queensland's mental healthcare statistics compare poorly with the rest of Australia in multiple areas, and there are some concerning trends over the last 10 years. Increases in some coercive practice indicators have occurred over the course of two planning documents that highlighted the need for respecting human rights and providing the "least restrictive treatment": *2007-2017 Queensland Plan for Mental Health and Connecting Care to Recovery 2016-2021.*

Examples of relevant Queensland insights and comparisons include:

1. In **residential** services, 36.8% of all episodes of care were involuntary. This is 7 times higher than NSW.

2. In **community** services, 1 in 4 service contacts were with a person with involuntary legal status, 72% above the national average. Queensland reported a 181% increase since the implementation of the mental health reform plan in 2007-8 compared with the relatively stable pattern in WA (see Appendix 2, Figure 1 and Table 1).

3. All **Treatment Orders** increased significantly following the introduction of the 2016 Mental Health Act, and are continuing to increase. [67]

4. The percentage of **Treatment Order reviews** being revoked has fallen significantly.

5. Numbers of **Forensic Orders** (per million) vary substantially and unfavourably for Queensland across Australia: from just 20 in WA 20, 30 in Victoria 30, 70 in NSW 70, and 200 in Qld (Appendix 3).

6. **Seclusion rates** were above the national average in 2020-21 [68], with Queensland reporting three of the highest rates among the ten worst performing hospitals. (Appendix 4, Figure 2 and Table 2).

7. **Physical restraint** began being reported in Queensland in 2017-18, the rates of which have increased year on year (Appendix 5, Figure 3 and Table 3). The Queensland Children's Hospital reported the nation's highest rate of physical restraint in 2021 and three of Queensland's adult hospital units reported the highest rates. The most recent preliminary Chief Psychiatrists national report indicates a drop in physical restraint between 2020-21 and 2021-22, although it is still close to double the number of events compared with 2017-18.

calls for change.

Lived experience recommendations have come from inquiries, research, and public advocacy in what is now a major global movement toward mental health system reform. The call for action is toward a fit-for-purpose community-based sector that is led by and meets the needs of people who access it. The World Psychiatry Association (WPA) states:

> *"The call for alternatives to coercion in mental health care is growing both within the profession and among people with lived experience of coercion in mental healthcare. There is widespread agreement that coercive practices are over-used [...] The question of whether coercive interventions can ever be justified as part of mental health treatment, to protect rights holders' own interests or on other grounds, is highly contested."* [69]

International and national recommendations for reforming the system and service provision for mental health consumers are well established and highly visible. Leverage points for change exist across the social, community and justice services and at all levels within the mental health system to create opportunities for prevention, early intervention, and more effective person-led support at all points on the intervention continuum.

The evidence points to opportunities for reform in multiple domains, including: lived experience empowerment; meeting international human rights obligations through federal, state and territory legislative amendments; independent oversight of an accountable, transparent system; improvements in organisational and professional culture; appropriate resourcing of the lived experience workforce; improved data governance, management and reporting; and approaches to mental health service delivery in accordance with a culture of care that is:

1. Person-led
2. Recovery oriented
3. Human rights-based
4. Culturally safe, and
5. Trauma-informed.

Examples of opportunities and recommendations to reform the misuse of coercive and restrictive practices in the mental health system include:

1. The Victorian Royal Commission into Mental Health made 16 recommendations specific to seclusion and restraint, including eliminating the practices over the next 10 years. [70] As a result of the Commission, the government's first Executive Director of Lived Experience was appointed to support mental health system reform.

2. Lived experience recommendations from the Victorian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability that change needed to occur in these major areas[71]:

    - Attitudes and culture
    - Training and education
    - Laws and policies
    - Funding
    - Establishing peer review committees to focus on restrictive practices
    - Access to supported decision-making and advance statements
    - Clear and transparent recording and notification of all restrictive practices, and
    - Further research on alternatives to alternatives to restrictive practices.

3. National Mental Health Consumer and Carer Forum's (NMHCCF) position that "it must be the aim of Australia's mental health services to work towards the elimination of restrictive practices and that they only be used as "safety" measures as an absolute last resort under extremely strict guidelines and by appropriately trained staff".[72]

4. The project undertaken by the Australian College of Mental Health Nurses and the National Mental Health Commission that recommended "consumers are actively involved in strategies to reduce seclusion and restraint". [73]

5. The Victorian Mental Illness Awareness Council (VMIAC) recommendation that the stories of people with lived experience of restrictive practices should be collected via surveys or interviews to build a complete data story; also describing concern that the Department of Health withheld consumer data that should have been publicly reported. [74]

6. The RANZCP recommendations to strengthen cultural approaches that are effective at reducing seclusion and restraint among Aboriginal and Torres Strait Islander people, Māori and Pasifika. [75]

7. A call to action in the 2020 WPA position statement supporting mental health professionals and their organisations to implement alternatives to coercion.[76]

8. Findings from the ALRC (2014):

    - "Significant inconsistency in the regulation of restrictive practices across jurisdictions, and the numerous frameworks 'conspire to make the legal framework in this area exceedingly complex'"; and
    - noting the opportunity to consider a national approach to reform of laws and legal frameworks to support the reduction, and where possible, elimination of restrictive practices.[77]

ALTERNATIVE APPROACHES

The WPA reinforce the broader knowledge base calling for a change to coercive practice in mental health care. While coercive practices occur across the scope of the health and social sectors, it is arguably the biomedical model, and particularly the psychiatric profession, that holds the balance of systemic and structural power and therefore the ability to influence legislation, policy, and practice in the mental health setting.

> *"The WPA wishes to emphasise that implementing alternatives to coercion is an essential element of the broader transition across the mental health sector toward recovery-oriented systems of care."*[78]

Psychiatry faces a cultural reckoning to move towards:

1. Taking a person-led, partnership approach: sharing power with consumers.

2. Using data and evidence-based tools to inform least restrictive practice.

3. Shifting to community-based psychiatry and replacing hospital-centric mental health systems and institutionalisation.

4. Collaborative engagement at the earliest possible point, particularly where there is agitation;[79] reducing environmental triggers and improving safety in inpatient settings and emergency departments.[80]

5. Increasing critical reflective practices and improved accountability of harm caused by coercive approaches.

6. Integrating lived experience knowledge, including balancing the interaction between "dignity of risk" and "duty of care": decreasing over-medicalisation, paternalism, and risk aversion in biomedical practice.

The WPA and RANZCP refer to trauma-informed models of care and service-level frameworks that have been evaluated and shown to reduce coercive practices, with the possibility of eliminating them. Enabling service level change partly depends on health services identifying, adapting, and delivering non-coercive models in their own contexts, such as:

- Six Core Strategies[81]
- Safewards program
- Perfect Care (Mersey Care, UK)
- Open door policies
- WHO's Quality Rights Initiative.

INITIATIVES FROM OTHER PLACES

There is significant local, national, and international activity focused on the reduction and elimination of coercive practices in mental health care. Sustained change efforts targeted at multiple parts of the system have created both structural change and 'pockets of excellence' in hospital-based and community-based psychiatry and allied mental health services. Recent and current initiatives include:

Victoria, Australia

Whole-of-system reform activities relating to the recommendations from the **Royal Commission into Victoria's Mental Health System** are underway to address the daily breaches of human rights and unlawful actions within their existing service system.[82] The Commission recognised that high rates of coercive treatment are a direct consequence of 1) the overall system design with its emphasis on crisis responses and hospital-based treatment; 2) service system capacity; and 3) culture.

Specific to eliminating seclusion and restraint, the Royal Commission recommended the Chief Officer for Mental Health and Wellbeing develop and lead a strategy towards elimination through three main drivers:[83]

- Improving accountability and transparency of restrictive interventions
- Supporting changes in workforce practice, and
- Ensuring consumer-informed planning and implementation.

The Victorian Department of Health provided a principled framework for communication and engagement around the strategy that included "adjusting for power imbalances" and applying human rights and cultural safety lenses. Acknowledging trauma, and "centring the experiences of people who have been secluded and/or restrained".

The Royal Commission also recommended that the mental health system reform be guided by an outcomes and performance framework with the purpose of increasing responsibility and accountability across government. The Victorian Government will publicly report progress against the framework domains, outcomes and indicators and increase accountability for improving the mental health and wellbeing system.

South Australia

The Central Adelaide Local Health Network (CALHN) began a comprehensive systems approach to reducing restraint and seclusion in all inpatient mental health units and EDs in 2020. This built on work that commenced in 2019 in a longer-stay inpatient rehabilitation unit.[84]

The results showed that across CALHN's 6 inpatient units, rates of restraint and seclusion had declined significantly and were possibly the lowest in Australia. Data collection and reporting from the EDs at the Royal Adelaide Hospital and The Queen Elizabeth in mid-2020 and significant reductions in the number, intensity and duration of restraint and seclusion events were achieved by

March 2021. Comparative ED data was not available as these were not routine collections at state or national levels.

The improvements were based on:

1. Integrated, Recovery Oriented, Trauma Informed Principles for Mental Health of Care

2. A systems and data driven approach to developing alternative pathways to care for people in crisis

3. Changes to service models across both inpatient and community teams to ensure acute inpatient stays for existing community consumers were planned and minimised

4. Staff training, monitoring, and reporting

5. Executive leadership (see Appendix 7)

Aotearoa New Zealand

In 2019 the Health Quality and Safety Commission launched the pilot Zero seclusion: safety and dignity for all, with the explicit aim of eliminating seclusion across NZ.[85] An interim target of 5 per cent or below by December 2023 was set, with the most recent data showing a decline for all major population sub-groups with the sharpest declines for Māori and Pacific peoples.

A comprehensive change package and quality improvement program support the system and practice changes, providing clear monitoring and reporting guidelines, access to a range of evidence-based interventions, and access to a centralised Zero Seclusion measures dashboard.

Catalonia, Spain

In 2019 the Catalan Consensus Guidelines for Practice and use of Containment: **Towards Zero Restraint**[86] were designed, based on commissioned research including systematic review, measurement, rates, and costs to inform domain experts and planners. Standard procedures, monitoring and liaison with the Department of Justice and Ethics committees were undertaken in the process.

Different target groups for included people with agitation in Intellectual and Developmental Disability (IDD), severe mental illness, and dementia; as well as different sectors and services: acute MH care, IDD care, Aged care, Justice Prison/Home, Ambulance, ER, acute care.

Innovations at one large urban hospital included comfort rooms, video surveillance with AI incorporated, and non-stigmatising and safer beds across five speciality areas (mental health, mental disability, psychogeriatrics, paediatrics and geriatric units).

The St John of God Hospital in Barcelona reported no restraint episodes in the subacute inpatient unit since January 2018, and their length of stay was shortened to 60 days. Seclusion and restraint in the acute inpatient unit have also reduced and been sustained by almost 10% since 2012.[87]

The Trieste Model, Italy

The Trieste Model is a deinstitutionalised, community-based mental health care model described as a "whole system, rights-based, recovery-oriented approach", established in the 1980s in Northeastern Italy. [88]

The "Trieste way" describes a novel psychiatric approach to care based on whole-person, holistic support; the person's environment, networks and social context; and their civil rights including, but not limited to, unrestricted movement, avoiding restrictive care and providing "socially meaningful work".[89] Of note is that there is an unrestricted open-door policy.

Recognised by the World Health Organization as a world standard for community psychiatry, the model is based on four main principles:[90]

- People experiencing mental health challenges live within their community and are considered citizens deserving dignity and respect.
- There is therapeutic value in including consumers in the community's daily activities.
- Consumers function best when their freedom is preserved in a strengths-based way.
- Working with consumers in the community creates an inclusive social fabric.

RESTORATIVE JUSTICE & HEALING

A comprehensive approach to addressing the significant harm inflicted on the survivors of coercive practices must consider the long-term impacts on the person over their lifetime; the outcomes for their families and carers; and the intergenerational impacts caused by systemic harm. The urgent requirement for restorative justice and healing for people with lived experience of coercive practices and forced psychiatric interventions are strongly visible across the international and national landscapes.

> *"The harms of institutionalization do not end when a person is released; even in freedom the impact of past trauma continues. Our relationships with family and friends can be destroyed. We are often impoverished and have lost a home and personal possessions. Our schooling or employment is interrupted; this makes it difficult to apply for jobs without disclosing the reason for gaps in our personal timeline. Psychiatric drugs can cause lasting changes in the brain that make it difficult to withdraw from those drugs, and cause irreversible damage to the liver, kidney, and endocrine systems as well as the brain."*[91]

Here, we represent restorative justice themes that have emerged from three major participatory projects with survivors of coercive practices and institutionalisation:

1. Not Before Time: Lived experience-led justice and repair. Advice to the Victorian Minister for Mental Health on Acknowledging Harm in the Mental Health System (2023).

2. Leading Healing Our Way. Queensland Aboriginal and Torres Strait Islander Healing Strategy (2020-2040).

3. Guidelines on Deinstitutionalization, including in emergencies. Committee on the Rights of Persons with Disabilities UNCRPD/C/5 (2022).

A major principle underpinning these themes is that people must be the custodians of their own healing, a non-negotiable aspect of restoring autonomy, dignity, choice, control and respect for the person's legal capacity and decision-making, where their human rights have previously been breached.[92] Healing must be considered in the context of people's culture and circumstances and must be acknowledged by the people of the system that caused the harm.

First Nations Peoples in Queensland set out a pathway for wellbeing, healing and preventing new trauma in their report, Leading Healing Our Way, describing a roadmap and five main priorities and actions for healing:[93]

1. Tell the truth:
    - Establish a formal truth-telling process
    - Make truth-telling safe for all
    - Gather, share, and teach stories and evidence
2. Stop the trauma:
    - Eliminate racism and trauma
    - Make systems culturally safe and accountable
    - Invest in community-led healing through culture
    - Build trauma-aware healing-informed workforces
3. Heal through culture:
    - Recognise the primacy of culture and its essential role in healing
    - Enable more than 60,000 years of culture to be at the centre of healing
4. Communities decide:
    - Invest in community capacity
    - Hand over decision-making to Aboriginal and Torres Strait Islander communities
5. Walk alongside:
    - Promote trauma-aware healing-informed approaches
    - Celebrate Aboriginal and Torres Strait Islander culture, strength, and resilience
    - Measure success through culturally relevant wellbeing measures

> *"[…] there is clear evidence that programs designed to tackle trauma – at its root causes, not its symptoms – through culturally based practices greatly benefit participants and also provide substantial benefits for governments. These include better returns on investments across education, health, justice and family wellbeing. Healing enables people to address distress, overcome trauma and restore wellbeing. It occurs at a community, family and individual level and continues throughout a person's lifetime and across generations."*[94]

Lived experience knowledge about restorative justice responses to mental health system-related harm describes that system leaders and people working within it must first acknowledge the harm. Truth and reconciliation begin with hearing people's stories about the harm that was done to them, and what they need to recover from the impacts of system harm. [95]

Victorians spoke of the harm that was caused to them in the State Acknowledgement of Harm Project, by narrow approaches that were deemed objective, yet disregarded the subjectivities of their distress and were a poor fit for their recovery:

> *"Narrow biomedical approaches to distress, pathologise difference, and our unique experiences. Narrow biomedicalism and a lack of diverse choice has often gone hand-in-hand with the use of force […] The objective and individualistic assessments of mental health also function to exclude the expertise and needs of families, carers and supporters. They can also be irrelevant or harmful to First Peoples, who may understand distress from more collectivist and integrated understandings of social and emotional wellbeing."*[96]

Following the acknowledgement of harm, the system needs to: cease coercive practices and immediately stop the system harm; provide immediate restitution by addressing people's immediate needs for healing and recovery; and prevent future harm by guaranteeing that harmful practices will not be repeated, and alternatives will be sustained.[97]

Lived experience advice on best practices to acknowledge harm in the mental health system were provided to the Victorian Minister for Mental Health and included the following six mechanisms:[98]

- Public (or state-based) apologies, including from professional mental health bodies
- Truth and reconciliation processes
- Individual reparations
- Collective reparations
- Symbolic reparations, and
- Guarantees of non-repetition.

Developing advice to the state for their role in the healing processes of people who have been harmed by mental health systems must be lived experience-led and informed by several concepts including: restorative justice principles; First Nations Person's knowledge; human rights, and other social justice ideology.

The recent Victorian lived experience-led justice and repair inquiry concluded with two recommendations to the Mental Health Minister and Government, and a range of alternatives. Firstly, that a restorative justice process must be embarked upon, followed secondly by a public apology issued in Parliament by the Victorian Government.

It is the MHPLEQ's recommendation that Queensland hear the powerful call of lived experience Victorians and begins this State's own acknowledgement and healing process.

conclusions.

The MHLEPQ advocates for systemic change toward the elimination of coercive practices within the mental health system in the shortest possible time frame. We use the umbrella term “coercive practices” to include any regulated and unregulated systemic, structural, and service-based mechanisms whereby people experiencing mental health challenges are subject to attitudes and treatment that compromise their human rights and cause them harm.

While calling for the elimination of coercive practices in the shortest possible timeframe, our members agree that only in the most extreme, serious, and urgent cases may a coercive practice be warranted, and these should always be subject to formal investigation as a systemic failure in care. In many cases, the use of coercive practices is a clinical choice that favours hospital protocols and routines and is not inevitable, or in the best interests of consumers. We agree with other consumer-led organisations around Australia that there is no reason why the elimination of coercive practices cannot happen more quickly than in the next ten years, with pockets of excellence already modelling alternative approaches to coercive practice.

Coercive practices remain embedded in psychiatry and mental health care today. We believe that the opportunities for timely, sustained, and meaningful change lie more widely than mental health service change. Sustainable, well-rationaled system change rests on an examination of the worldviews, mental models, relationships, and power dynamics within the structures of the existing system.

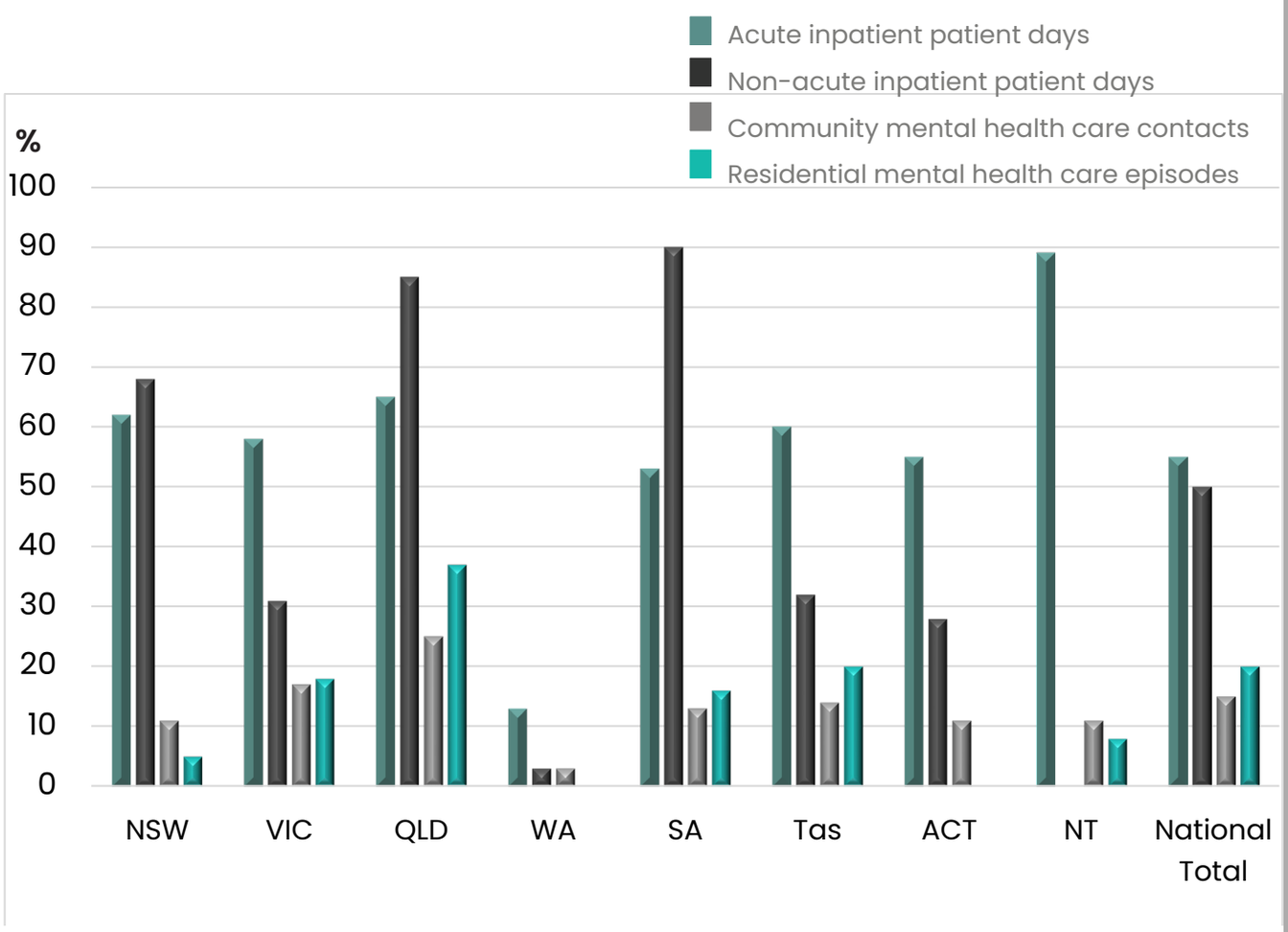
For people who have been harmed by coercive practices, restorative justice must be provided according to the person’s own individual healing needs, according to their own cultural context, and with full accountability by the state. The change will occur when consumer-led, service-level recommendations are combined with a societal paradigm shift and structural changes that address the upstream determinants of impending mental health crises, but most importantly, a rights-based, person-led and trauma-informed approach in how people are responded to.

APPENDIX 1: ABBREVIATIONS

ALRC	Australian Law Reform Commission
AOD	Alcohol and other Drugs
CALHN	Central Adelaide Local Health Network
FO	Forensic Order
LEAG	Lived Experience Advisory Group
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer (or questioning), intersex, and asexual (or allies)
MHLEPQ	Mental Health Lived Experience Peak Queensland
MHRT	Mental Health Review Tribunal
NMHC	National Mental Health Commission
NMHCCF	National Mental Health Consumer and Carer Forum
OPCAT	Optional Protocol to the Convention against Torture
QH	Queensland Health
QMHC	Queensland Mental Health Commission
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SPT	Subcommittee on the Prevention of Torture
TA	Treatment Authority
TSO	Treatment Support Order
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
VMIAC	Victorian Mental Illness Awareness Council
WHO	World Health Organization
WPA	World Psychiatric Association

APPENDIX 2: INVOLUNTARY TREATMENT DATA

Figure 1: Involuntary Mental Health Status, by States, Territories and Setting, 2019-2020



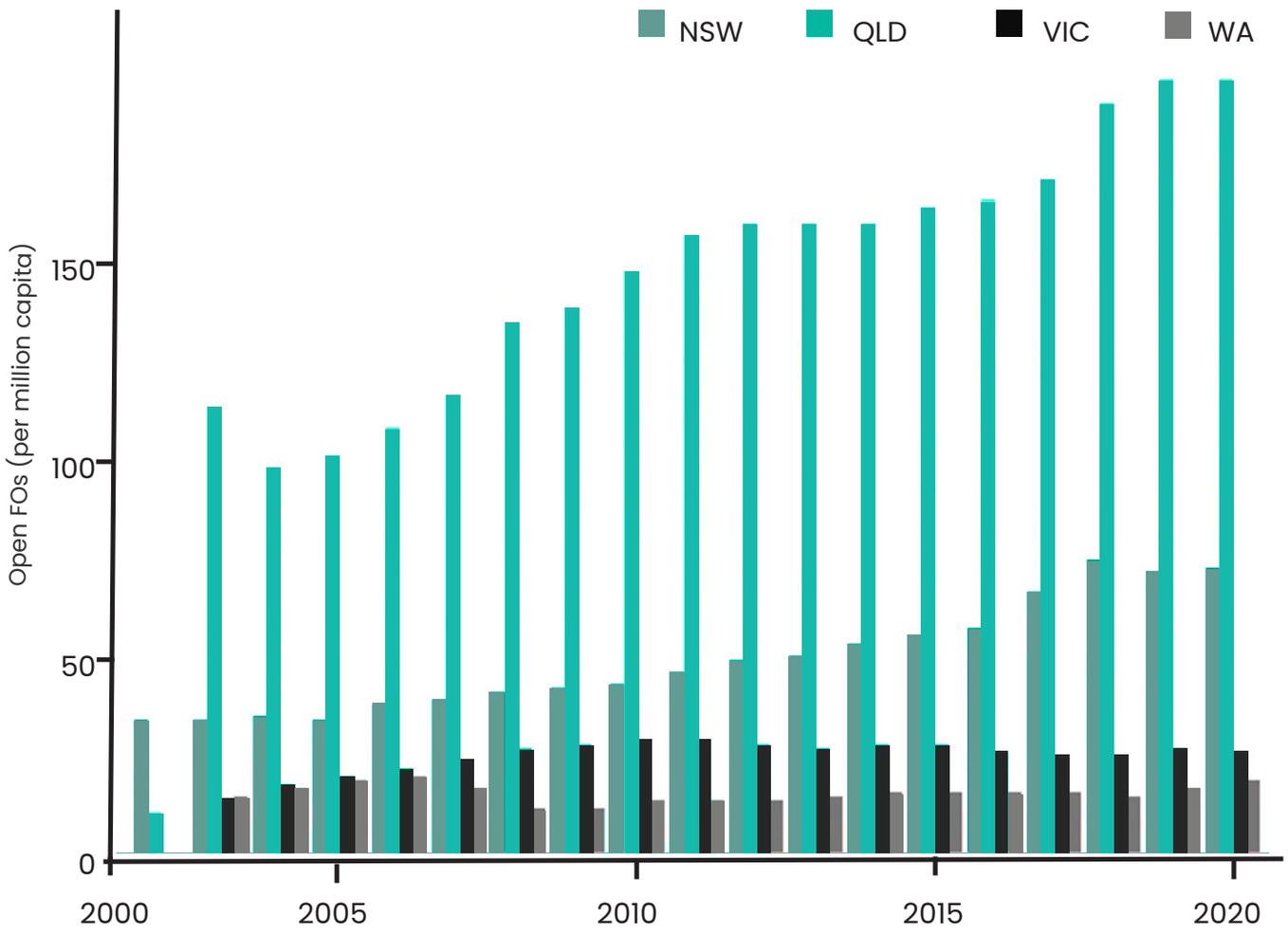
YEAR	QLD	WA
2007-08	9.0	2.6
2008-09	15.3	3.2
2010-11	20.7	3.5
2013-14	22.4	2.7
2016-17	22.3	3.1
2019-20	25.3	3.1

[99]Note: there is no national or state/territory collection of involuntary treatment in Emergency Departments or other hospital units for people with mental health conditions.

Table 1: Aggregated Queensland and WA data on involuntary community orders as a Percentage of Community MH Contacts.[100]

APPENDIX 3: OPEN FORENSIC ORDERS

Figure 2: Number of Open Forensic Orders per Million, at 31 December, by Year & Jurisdiction



APPENDIX 4: NATIONAL, STATE & TERRITORY SECLUSION DATA

Events per 1,000 bed days

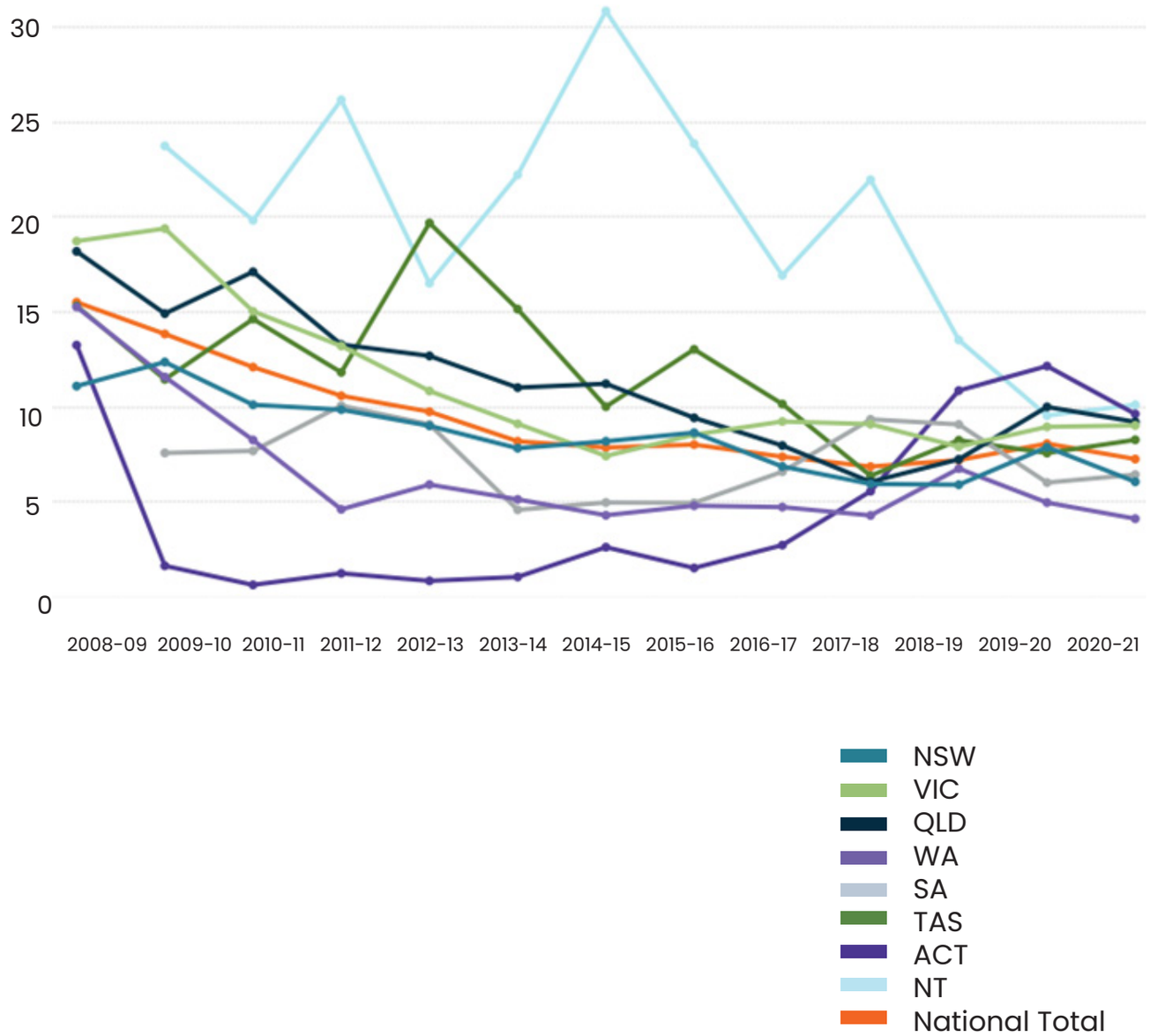


Figure 3: Rate of Seclusion Events, Public Sector Acute MH Hospital Services, States and Territories, 2008-9 to 2020-21 (Source AIHW)

INDICATOR	2017-18	2018-19	2019-20	2020-21	2021-22
Seclusion events per 1,000 acute bed days	6.1	7.3	10	9.3	7.3
Proportion of acute episodes with one or more seclusion events	2.1	2.4	3.1	2.7	2.5
Average (mean) duration of seclusion events (hours) in acute episodes	2.8	3.2	3.7	3.5	5.3

Table 2 : National Seclusion Indicators

APPENDIX 5: NATIONAL PHYSICAL RESTRAINT DATA

Figure 4: Rates of Physical Restraint Events (2015-16 to 2020-21, Public Sector Acute MH Hospital Services, by States &Territories

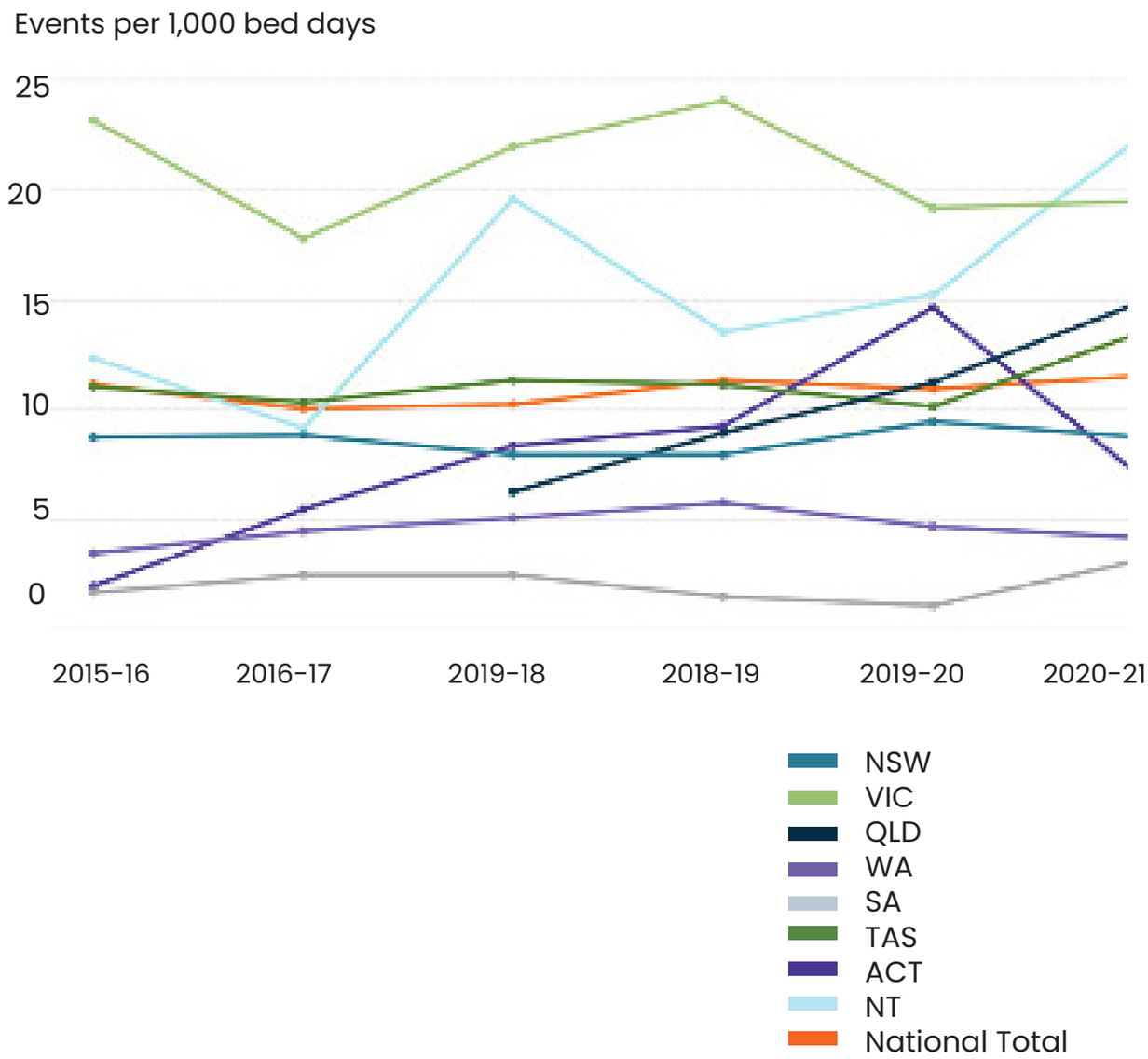


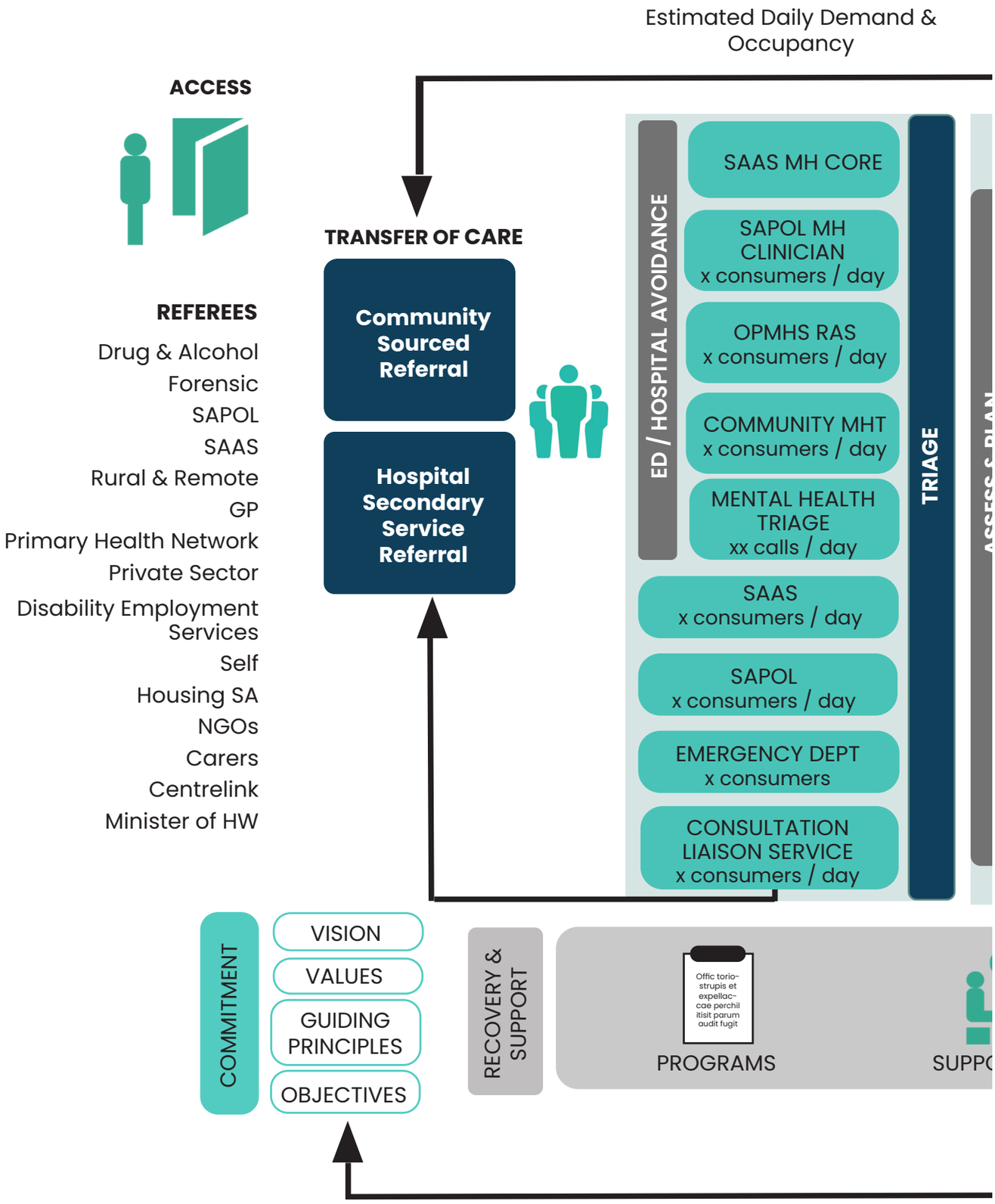
Table 3: Total Physical Restraint Events per 1,000 Acute Bed Days

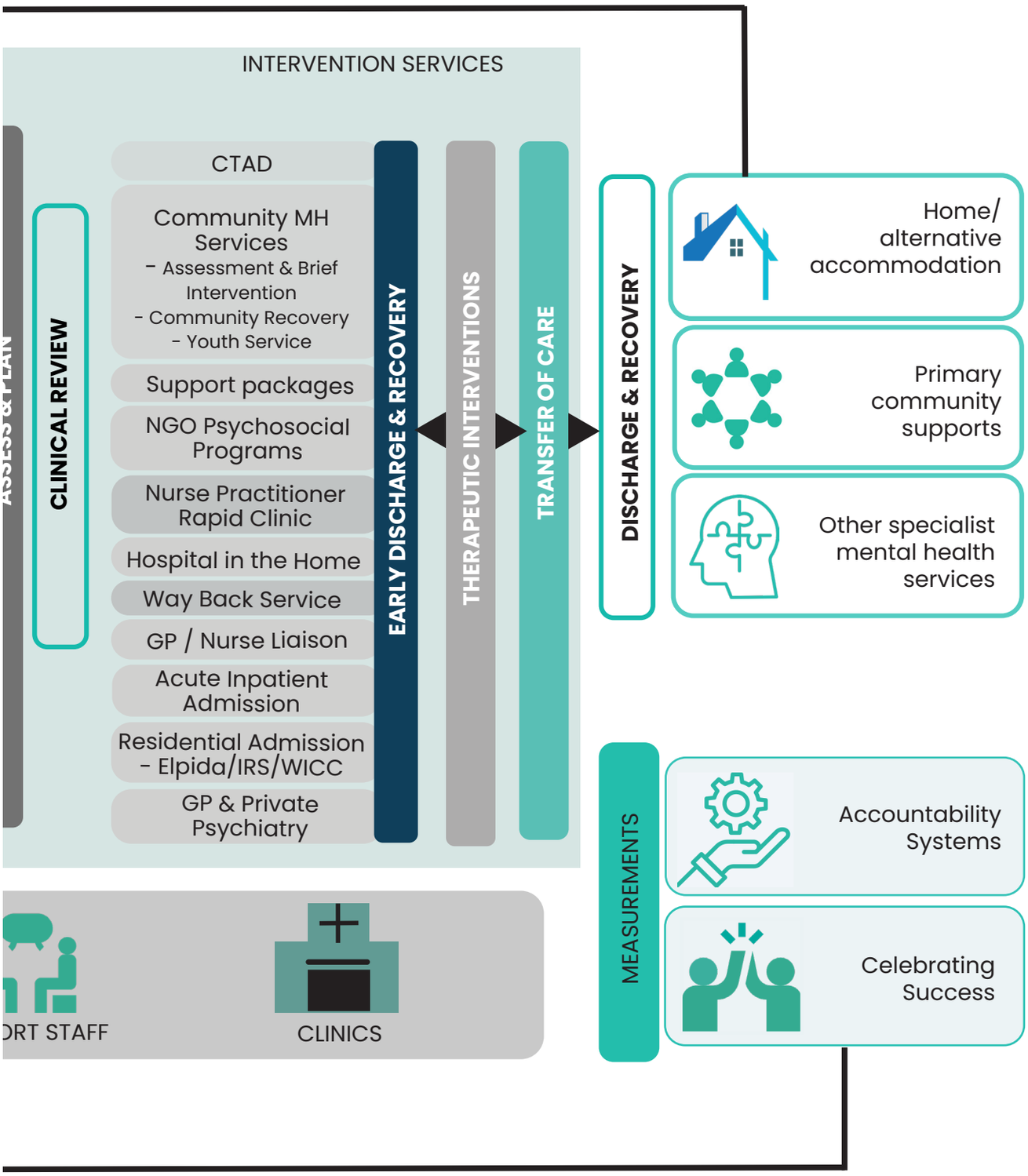
INDICATOR	2017-18	2018-19	2019-20	2020-21	2021-22
Physical restraining events in acute episodes	1,835	2,703	3,503	4,501	3,345
Total physical restraint events per 1000 bed days	6.4	9.2	11.7	15.2	11.3

APPENDIX 6: EXAMPLE OF A SYSTEMS APPROACH

Figure 5: CALHN integrated recovery oriented, trauma informed principles for mental health care.[101]

Figure 6 Whole of Service Flow Model: CALHN Systems Flow Model: Design.[102]




INTERVENTION SERVICES
CLINICAL REVIEW
CTAD
Community MH Services
- Assessment & Brief Intervention
- Community Recovery
- Youth Service
Support packages
NGO Psychosocial Programs
Nurse Practitioner Rapid Clinic
Hospital in the Home
Way Back Service
GP / Nurse Liaison
Acute Inpatient Admission
Residential Admission - Elpida/IRS/WICC
GP & Private Psychiatry
EARLY DISCHARGE & RECOVERY
THERAPEUTIC INTERVENTIONS
TRANSFER OF CARE
DISCHARGE & RECOVERY
Home/ alternative accommodation
Primary community supports
Other specialist mental health services
MEASUREMENTS
Accountability Systems
Celebrating Success
CLINICS

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