MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

Statement of Advice: Responses to Queensland Health Restrictive Practices Policy Statement Discussion Paper

Preamble

This advice is based on the collective knowledge and experiences of the members of the MHLEPQ Coercive Practices Lived Experience Advisory Group (LEAG). While member experiences were varied and broad, all individuals who were exposed to restrictive practices found them traumatising. We note that Human Rights and Patient's Rights are individual rights, not population-based rights, and as such are essential to every person. The positions proposed in this document must be accepted by Queensland Health (QH) as true for the individuals who experienced them ***beyond question and justification***.

It is important that the Queensland Health position statement reflects that people using the Queensland mental health system are not mere statistics, but unique individuals with their own context and background. That harm ***is*** being done by use of restrictive practices (RPs) in the Queensland Mental Health system today, is therefore a categorical truth - even if the system seeks to minimise such harm, where possible.

There is an ethical issue with the ongoing use of RPs given that there is little or no evidence to support their therapeutic benefits and considerable evidence to show the harmful impacts. The lack of consumer-centred data collection and public reporting on the current use of restrictive practices (both regulated and unregulated) makes it difficult to monitor both the impacts and the current trends of the use of such practices, which in turn undermines the Government's obligations under the Convention on the Rights of Persons with Disabilities (CRPD) to uphold individual human rights.

Issues for discussion

This summary provides the perspectives and recommendations of people with lived experience of restrictive practices. Feedback by the LEAG to the questions posed by Queensland Health in their discussion paper[1] is provided under six thematic headings:

- Principles and Assumptions
- Human Rights Frameworks and the Queensland Legislative Environment
- Language, Discourse, and Terminology
- Culture of Care
- Transparency and Accountability
- Compliance and Oversight

Principles and assumptions

1. ***The use of any restrictive practice represents a systemic failure of care*** across

[1] [Key Policy Positions] What are your thoughts on these policy positions? Do they reflect the positions Queensland Health should commit to? Are there other concepts to explore here? What else should be included? Do you have any other suggestions? [Guidance to HHS] What could we do differently to prevent or reduce the use of restrictive practices and minimise harm when they are used? [Evaluating outcomes] Do you have other suggestions on ways to evaluate the impact of the policy statement – particularly those that may best capture feedback from people with lived experience?

the continuum from community to hospital-based care[2]. Settings where restrictive practices occur includes the triage line, ambulance /police /emergency department transfers, clinical assessment and then again during transfer to inpatient or out-patient services and long stay residences. ***We recommend*** that the presence of restrictive practice in routine operating policies and procedures is identified, and all use of RP is systematically investigated using restorative justice principles, monitored, publicly reported, and independently overseen by Lived Experience workforce.

2. ***The use of restrictive practices causes harm,*** with acute and long-term impacts for the person subjected to the practice, the person performing it, and others witnessing it. It is important that this perspective is clear and not obscured or diluted in any way, even if the use of such practices could be justified by an imminent danger to life – it still causes harm.
3. ***The impacts of medical trauma***[3] caused by restrictive practices are diverse and extend beyond the experience to affect other activities of daily life. This is true for people who are subjected to the practice, as well as for those who witnessed. Related impacts include future distress and unwillingness to seek general health care and social sector services such as GPs, dentists, police and legal; and distrust with fully disclosing mental health-related status to mental health professionals, friends, partners, family, and colleagues.
4. ***There is a breach of professional ethical standards*** if the practice in any way could have been avoided. ***We advise*** positioning the use of RPs as reportable events, with every occurrence clearly documented, investigated and findings reported, including reflections and actions on possible alternatives.
5. ***Restrictive practice causes moral injury and psychological distress*** in both the short and long term, representing a significant psychosocial workplace health and safety hazard for staff. ***We recommend*** that every incident of RP is treated as a serious work health and safety issue and a full investigation examines the systemic and environmental solutions to RP use (over policy and administrative controls), as per Queensland's *Managing the risk of psychosocial hazards at work* Code of Practice 2022[4].

Human Rights Frameworks and the Queensland Legislative Environment[5]

5. ***Human rights are breached*** when restrictive practices are used, affecting the person subjected to the practice and the people applying and witnessing it. ***We advise*** including the key points made by the World Psychiatric Association on the clinical, moral, legal, and human rights grounds for alternatives to coercion, in the QH

[2] RPs are used when there is a failure to intervene, deescalate, adapt care, have other safeguards in place, communicate effectively, or recognise signs or extent of escalation prior to the incident.
[3] Medical trauma is defined as a set of psychological and physiological responses to pain, injury, serious illness, medical procedures and frightening treatment experiences (International Society for Traumatic Stress Studies: Clinician Fact Sheet/What is Medical Trauma?), accessed 31.01.2023. Traumatic stress and the possibility of Posttraumatic Stress Disorder (PTSD) in consumers is well evidenced in the medical literature and public domain (Medical Traumatic Stress: What Health Care Providers Need to Know), accessed 31.01.2023
[4] https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0025/104857/managing-the-risk-of-psychosocial-hazards-at-work-code-of-practice.pdf
[5] Including legislation and relevant Human Rights Conventions and Instruments

position statement.[6] In particular, commitment to the principles of deinstitutionalization and fully informed consent are required, as per recent recommendations by the Committees on the Rights of Persons with Disabilities.[7,8]

6. ***The United Nations Convention on the Rights of Persons with Disabilities (CRPD)*** is the most powerful international treaty for protecting the rights of people with psychosocial disability (see Appendix 1: Key findings from analysis of two key CRPD documents as they relate to the Queensland Mental Health System). ***We recommend*** that the QH position statement advocate for the inclusion of the CRPD framework across all mental health system policies, services, and programmes, in accordance with advice by the United Nations, Public Advocate[9] and other key organisations.
7. ***We advise*** that the full range of legislation and human rights instruments relevant to consumers of the mental health care services in Queensland be stated in the QH position statement.

Language, Discourse, and Terminology

8. There is a ***power differential in the language and discourse*** used in the QH document. Where statements are made by QH, the language is definitive, and objectivity is implied (moralism). These statements often conflict with lived experience (LE) realities, which are assumed to be subjective. LE views are often stated from the position of mental health professionals. ***We recommend*** that LE statements should be definitive and written as absolute and irrefutable. For example, replace "can be" with the word "is" in the following statement: "The use of restrictive practices in mental health alcohol and other drugs services ~~can be~~ ***is*** distressing and traumatising".
9. ***We advise use of the phrase "***Restrictive practices should never be used unless a person's life is in imminent danger" in the QH position statement.

Culture of Care

10. Restrictive practices are still viewed as acceptable to the Queensland mental health system. Justifications and enablers of RP include:
    i. "Perceived benevolence" and paternalism, which perpetuate the myth of RPs being for the good of the person being subjected to the practice, or for the 'greater good' of everyone involved.
    ii. Moralising (where preferences are presented as values) is used as a defence mechanism against action and change

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[6] World Psychiatric Association (2020). Implementing Alternatives to Coercion in Mental Health Care. Discussion Paper from the WPA Taskforce. Link here

[7] Committee on the Rights of Persons with Disabilities CRPD/C/AUS/CO/2-3 (2019). Concluding observations on the combined second and third periodic reports of Australia. https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpdc5-guidelines-deinstitutionalization-including, accessed on 06.02.2023

[8] Committee on the Rights of Persons with Disabilities CRPD/C/5 (2022). Guidelines on deinstitutionalization, including in emergencies. http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsnzSGolKOaUX8SsM2PfxU7sdcbNJQCwlRF9xTca9TaCwjm5OlnhspoVv2oxnsujKTREtaVWFXhEZM%2F0OdVJz1UEyF5leK6Ycmqrn8yzTHQCn, accessed on 06.02.2023

[9] Public Advocate (Qld). August 2022, p.35. *Better Pathways: Improving Queensland's delivery of acute mental health services.*

iii. Dehumanising the person subjected to the RP, justifying and excusing abuses of power.
iv. Using RPs as behavioural management, punishment, or for the convenience of others is an unacceptable structural issue that should be addressed as such, particularly when there is inadequate staffing.

11. ***We recommend addressing organisational culture*** in the QH position statement by including harm reduction concepts from Priority 4 of *Better Care Together*. For example: "Safety and quality improvement within a learning culture is the foundation of efficient and effective MHAOD treatment, care and support in an environment of ever-increasing demand and complexity […] Increasing capacity and capability in healthcare teams requires a learning culture which encourages improvement-focused participation from people accessing services, their families and carers and staff. A learning culture within services enables a best practice approach to care and to personal, physical and / or psychological safety and a restorative just culture relating to incidents" (p. 36).
12. ***Marked power imbalances exist*** across professions and disciplines within the mental health system. Peer support workers perspectives are diminished by the hierarchical nature of psychiatry. ***It is crucial that*** these power imbalances are addressed through a paradigm shift toward person-centred partnership, trauma-informed practices, supported decision-making frameworks, and restorative justice approaches. ***We advise*** that peer workers are consulted with prior to the use of any regulated restrictive practice and recorded in the consumer's notes, including the peer worker's advice for care.
13. ***Evidence-informed models*** for culturally safe and trauma-informed mental healthcare should be specified in the QH position statement, for example, MercyCare's Perfect Care, Safewards etc.
14. ***QH investment in consumer-driven research*** should be clearly stated in the position statement, acknowledging the importance of an organisation-wide commitment to a learning culture.
15. ***Commitment to reflective practice principles*** should be explicitly stated. ***We recommend*** that QH advise the implementation of post-seclusion/RP counselling for consumers, carers and clinicians.
16. Many QH mental health system environments are non-therapeutic, create threat and antagonism, and constitute a restrictive environment. An example is the case of security guards routinely putting on gloves in anticipation of the need to physically restrain people who present to mental health wards.

Transparency and Accountability

17. ***We advise that*** the QH position statement must reference any relevant authorising jurisdiction, to provide an audit trail to where authoritative power exists, for example, the Chief Psychiatrist, Mental Health Act, AHPRA etc.
18. Current data about restrictive practices within QH MHAOD services is extremely difficult to access. ***We recommend*** that there is full transparency in the QH position statement about available data and the importance of capturing the experiences of people with lived experience of RPs. ***We recommend*** QH resource the MHLEPQ to lead a consumer consultation on necessary lived experience data capture and reporting.

19. ***Robust decision-making tools*** should be involved prior to and throughout the use of any RPs, aligned with principles of supported decision-making as per the Mental Health Act 2016[10]:
    i. Every person can express their will and preference
    ii. A person with disability has the right to make decisions
    iii. A person with disability can expect to have access to appropriate support to make decisions.

    The use of which should be documented, reported, reviewed and accessible to the person subjected to the RP and their supporters.
20. ***We recommend*** that staff and service leaders who subject people to the use of restrictive practices should be fully accountable for reviewing their practice, involved in prevention of its future use, and work to remove the emotional burden for system reform from lived experienced people.
21. ***Failures in care are system failures and should always be investigated*** using restorative justice principles. Inquiry into incidents of RP should include a focus on:
    i. Was the least restrictive practice possible used?
    ii. Where did care fail to require the use of a RP?
    iii. What were the harmful impacts caused in relation to:
        a. Human Rights?
        b. Cultural Safety?
        c. Workplace Health and Safety?
    iv. Collaboration between the person receiving care, their supporters, and the multidisciplinary team to:
        a. Ensure full disclosure of incident documentation with the person receiving care (and /or their carers and advocate); and
        b. Assess personal impact and harm caused to the person receiving care and produce a trauma report.
    v. Publicly accessible systemic reporting.
    vi. Evaluation and recommendations for changes to future systemic and individual care.
    vii. Partnership-based opportunities for LE collaboration on quality improvement and change management.
    viii. The investigation should be led by a peer worker and audited by people with LE of restrictive practice.

Compliance and Oversight

22. While the QH Restrictive Practices Position Statement is acknowledged to provide non-enforceable guidance only, ***we advise that*** any statement about compliance, oversight and monitoring functions that exist outside of this document be explicitly referenced.
23. Regulated and non-regulated restrictive practices are considered by the LEAG in the category of broader coercive control. The same standard of monitoring, oversight, and accountability should be present for all coercive practices.

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[10] See s 14 (3) Mental Health Act 2016: A person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2016-005, accessed 31.01.2023

24. Lived experience leadership is underutilised in the QH mental health system. ***We advise that*** the QH position statement includes recommendations from *Better Care Together* for system and service reform, "This relies on effective leadership across services and the system to drive an improvement focused service culture and one which invests in building the engagement and capability of service leaders, including those with lived experience, staff and service users and their families and carers" (p. 36).

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Appendix 1: Key findings[11] from analysis of two CRPD documents[12] as they relate to the Queensland Mental Health System

1. ***Restrictive practices in both hospital and community settings*** constitute "institutionalization" as defined by the United Nations Convention on the Rights of Persons with Disabilities. Institutionalization is a discriminatory practice against persons with disabilities and is in breach of article 5 of the Convention. ***The CRPD concludes*** that there is a Duty of States parties to end institutionalization in all forms to uphold individual human rights to ***Equality and non-discrimination*** (article 5)

> *Mental health settings where a person can be deprived of their liberty for purposes such as observation, care or treatment and/or preventive detention are a form of institutionalization […] institutionalization on the basis of disability, separately or in combination with other grounds, amounts to a prohibited form of discrimination*[13]

2. Duty of States parties to end institutionalisation is based on several articles including ***Freedom from exploitation, violence and abuses*** and ***Protecting the integrity of the person*** (articles 16 and 17)***,*** where persons with disabilities are exposed to forced medical intervention without their "free, prior, and informed consent", in violation of articles 15 and 25 (Guidelines, p.1). Strategies and action plans were called for:

> *States parties should adopt a high-quality and structured plan for deinstitutionalization, which must be comprehensive and contain a detailed action plan with timelines, benchmarks and an overview of the necessary and allocated human, technical and financial resources (ibid, p.10)*

3. ***Equal recognition before the law*** (article 12) should be enabled by a consistent supported decision-making framework, as recommended by the Australian Law Reform

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[11] Note that all 33 Articles in the CRPD apply to the individual rights of people living with disability, including psychosocial disability. This analysis provides findings that are most relevant to people seeking mental health services for their experiences of psychosocial disability, rather than in other settings such as forensic institutions, or disability services approved by the NDIS, due to the narrower nature of this work.
[12] Committee on the Rights of Persons with Disabilities CRPD/C/5 (2022). Guidelines on deinstitutionalization, including in emergencies ***AND*** Committee on the Rights of Persons with Disabilities CRPD/C/AUS/CO/2-3 (2019). Concluding observations on the combined second and third periodic reports of Australia
[13] Committee on the Rights of Persons with Disabilities CRPD/C/5 (2022). Guidelines on deinstitutionalization, including in emergencies, p.2 & p.9. http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsnzSGolKOaUX8SsM2PfxU7sdcbNJQCwlRF9xTca9TaCwjm5OlnhspoVv2oxnsujKTREtaVWFXhEZM%2F0OdVJz1UEyF5leK6Ycmqrn8yzTHQCn, accessed on 06.02.2023.

Commission, 2014[14]. The human right to legal capacity is total and is denied by the process of institutionalisation:

where persons with disabilities, including those placed in institutions, are subjected to guardianship, forced mental health treatment or other substituted decision-making regimes, those measures should immediately be lifted. To prevent forced mental health treatment, affirmative, free and informed expression of consent by the person concerned is required (CRPD Guidelines on deinstitutionalization, including in emergencies 2022, p.8)

4. ***Right to liberty and security of person*** (article 14) is denied a person who is subjected to restrictive practices, depriving their liberty based on impairments.

All legislative provisions that authorize the deprivation of liberty or other restrictions on liberty and security of person based on impairment, including involuntary commitment or treatment based on "mental illness or disorder", should be repealed (ibid., p.8)

5. The CRPD Committees in both 2019 and 2022 made recommendations to ensure that article 15, ***Freedom from torture and cruel, inhuman or degrading treatment or punishment*** was upheld via legislative and administrative mechanisms, concluding that:

Provisions in mental health laws allowing for the institutionalization of persons with disabilities should be abolished (ibid, p.9)

Establish a nationally consistent legislative and administrative framework for the protection of all persons with disabilities, including children, from the use of psychotropic medications, physical restraints and seclusion under the guise of "behaviour modification" and the elimination of restrictive practices […] (Concluding observations, p.6.)

6. Practices that violate ***Living independently and being included in the community***, Article 19 should be avoided, including adding more beds, replacing large institutions with smaller ones, renaming institutions, or "applying standards such as the principle of the least restrictive alternative in mental health legislation" (Guidelines, p.3).

7. In accordance with the Sustainable Development Goal targets 3.7 and 3.8, article 25, ***Health*** are recommended in the 2019 CRPD Committee Concluding Observations that (p.10):

    a. *All persons with disabilities, in particular persons with disabilities living in remote areas, Aboriginal and Torres Strait Islander persons with disabilities, persons with intellectual or psychosocial disabilities, persons with disabilities living in institutions and women and children with disabilities, have access to information on an equal basis with others and to affordable, accessible, quality and culturally sensitive medical equipment and health services, including sexual, reproductive and mental health services;*

    b. *All health-care services are based on a non-discriminatory, human rights model of*

[14] Australian Law Reform Commission (2014). *Equality, Capacity and Disability in Commonwealth Laws. Final Report.* https://www.alrc.gov.au/wp-content/uploads/2019/08/alrc_124_whole_pdf_file.pdf, accessed 07.02.2023

disability and that any medical treatment is provided with the free and informed consent of the person concerned prior to any medical treatment.

8. Relating to article 31, ***Statistics and data collection,*** the importance of disaggregated data according to personal identity indicators including ethnicity, age, gender, sex, sexual orientation, ability and socioeconomic status and attributes of admission and institutionalisation is highlighted (Guidelines, p.10).

This includes collection of reliable, accessible and up-to-date records of the numbers and demographics of persons in psychiatric or mental health settings, records of whether the duty to allow persons with disabilities to leave institutions has been fulfilled, records of the number of persons who have exercised the option of leaving, and other information concerning planning for those who are yet to leave institutions.

9. In their *Guidelines on deinstitutionalization, including in emergencies 2022 (p.19),* the Committee recommend the following relating to article 32, ***International cooperation:***

International coordination of efforts to support deinstitutionalization are important to prevent the replication of bad practices, such as promotion of the medical model of disability and coercive mental health laws. States parties should consider establishing an international platform for good practices on deinstitutionalization, in close consultation with persons with disabilities, especially survivors of institutionalization, and their representative organizations.

10. Calls to action by both Committees relating to access to data and records, and the establishment of formal mechanisms of monitoring were made, relating to article 33 ***National implementation and monitoring:***

States parties should honour and facilitate personal data requests from survivors of institutionalization in public and private settings without restriction. States parties should not restrict or deny access to medical records by invoking public health or public order as grounds (Guidelines p.19)

Establish a formal mechanism and ensure sustainable and adequate funding for the meaningful engagement of persons with disabilities and their representative organizations in the implementation and monitoring of the Convention (Concluding observations p.12).

11. In relation to equitable access to support systems, networks, and services for people living with disability, the Committee recommended the following in their *Guidelines on deinstitutionalization, including in emergencies 2022* (pp. 11-13):

Support persons, circles of support and support networks may be chosen by persons with disabilities only, and not by third parties such as judicial or medical authorities, family members or service providers. Supporters should respect the will and preferences of persons with disabilities. Support persons should never be appointed against the will of persons with disabilities.

Peer support should be self-directed, independent of institutions and medical professionals, and autonomously organized by persons with disabilities. It is especially important for survivors of institutionalization, and in the interests of consciousness-raising, supported decision-making, crisis support and crisis respite, independent living, empowerment, income generation, political participation and participation in social activities.

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States parties should ensure that options outside the health-care system, that fully respect the individual's self-knowledge, will and preferences, are made available as primary services without the need for mental health diagnosis or treatment in the individual's own community. Such options should meet requirements for support related to distress or unusual perceptions, including crisis support, decision-making support on a long-term, intermittent or emergent basis, support to heal from trauma, and other support needed to live in the community and to enjoy solidarity and companionship.

States parties should ensure that access to mainstream services is without discrimination and is not conditioned by, withheld or denied on the basis of assessments, family or social support, medication compliance, any determination of "severity" of disability or perceived intensity of support requirements, any finding of a "mental health condition" or any other disqualifiers

Ends