Health Service Directive (HSD) for the Reduction and Elimination of Restrictive Practices – Consultation Advice

23 September 2025

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (**MHLEPQ**) respectfully acknowledges and honours the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of trauma within the mental health system. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. These historical and ongoing injustices have compounded the challenges faced by First Nations (Aboriginal and/or Torres Strait Islander) peoples, affecting their social and emotional wellbeing.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their own healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit. In honouring their wisdom and experiences, we commit to supporting their self-determination and promoting equitable and culturally responsive approaches to mental health care.

MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK
QUEENSLAND

Executive summary

Mental Health Lived Experience Peak Queensland (**MHLEPQ**) support a system that upholds human rights, recovery and cultural safety. We therefore welcome Queensland Health's proactive work in establishing a Health Service Directive (**HSD**) to require action plans to eliminate and reduce restrictive practices. We also welcome the opportunity to provide advice on it. Effectively tackling the use of restrictive practices requires collaborative work that centres people with lived experience.

MHLEPQ supports the abolition of restrictive practices. We support abolition because our community tells us about the our current coercive mental health systems cause:

> 'You're not supposed to walk into a room and point at me and tell me to go home because there's nothing you can put into me.'[1]

We support the abolition of these practices because people deserve better:

> 'I'm a human, you're supposed to be a professional and supposed to help other humans in need.'[2]

Restrictive practices are a denial of human rights[3]; denials legitimised through government policy. They are a barrier to change and better lives because they help hold the most unhelpful parts of the mental health system in place.

The decision by Queensland Health to create a HSD to take efforts to eliminate and reduce restrictive practices is an incremental one. It takes us marginally closer to this goal. We think within the parameters of what a HSD can do, it can and should go further.

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[1] *MHLEPQ - Shining a Light - Coercive Practices*: *Coercive Medical Practices - 'We Are Human'* (Directed by Mental Health Lived Experience Peak Queensland, 14 November 2024) <https://www.youtube.com/watch?v=NZWzrtngRY4> ('*MHLEPQ - Shining a Light - Coercive Practices*').

[2] Ibid.

[3] Committee on the Rights of Persons with Disabilities, *General Comment No. 1, Article 12*: *Equal Recognition before the Law,* (UN Doc. CRPD/C/GC/1 (19 May 2014), 2014); Chris Maylea and Asher Hirsch, 'The Right to Refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities' (2017) 42(2) *Alternative Law Journal* 149.

We aim to provide Queensland Health with practical advice that can strengthen this HSD to better do what many Queensland Health staff, clinicians, family members and people with lived experience want: eliminate restrictive practices.

Acknowledging the important step to develop and consult this draft HSD requiring action plans, we provide 11 recommendations as part of our advice. These recommendations fall under three themes:

- **Amend the policy framework:** The HSD and its associated documents should be significantly amended. This includes removing the phrase "where safe and possible", better acknowledging the significant harm caused by restrictive practices, and rewriting the HSD and patient information sheets to clearly articulate the case for change.
- **Strengthen accountability and human rights:** Queensland Health must act as the system steward by setting clear objectives and key performance indicators for Hospital and Health Services (**HHSs**), including what happens if HHSs fail to comply with the HSD. As part of this the policy framework, and in particular the HSD itself, require a significant revision based on Queensland's human rights laws.
- **Mandate co-design and collaboration:** The HSD must mandate engagement with people with lived experience, moving from "may" to "must". This includes better articulating the crucial roles of peer support workers, other lived and living experience workers, and independent patients' rights advisers. The development of a family-carer information sheet should also be considered to support the rights of a person with lived experience.

MHLEPQ is committed to working collaboratively with Queensland Health to implement these changes and create a mental health system that is safe, rights-based, and genuinely person-led.

Advice on Health Service Directive and Associated Documents

MHLEPQ welcomes the proactive work by the Queensland Government, including Queensland Health, in establishing and consulting on this Health Service Directive (**HSD**) regarding the reduction and elimination of restrictive practices. We also welcome the opportunity to provide feedback on these important documents and to elevate the voices and expertise of our members.

What the HSD is about

The HSD is an order from Queensland Health to Health and Hospital Services (HHS's) to create action plans to eliminate and reduce restrictive practices in a range of settings, including mental health settings. The HSD does not change the laws that currently permit individual practitioners to use restrictive practices. Clinicians will still be authorised to use these practices. Instead, the HSD requires HHS's to develop an action plan about how they will monitor, eliminate and reduce these practices at an organisational level.

MHLEPQ has been provided seven documents to give advice on. These are:

- Health Service Directive (Attachment 1)
- Guideline to Health Service Directive (Attachment 2)
- Chemical Restraint Patient Information Sheet (Attachment 3)
- Environmental Restraint Patient Information Sheet (Attachment 4)
- Mechanical Restraint Patient Information Sheet (Attachment 5)
- Physical Restraint Patient Information Sheet (Attachment 6)
- Easy Read Patient Information Sheet (Attachment 7).

Together, the HSD and associated documents provide a mechanism for Queensland Health to require Hospital and Health Services to establish an action plan for the elimination and reduction of restrictive practices where safe and possible. These are organisation-focused documents that are intended to create structures to guide

individual clinical decision-making towards elimination and reduction of restrictive practices.

Our advice is based on our broad organisational knowledge and capacity as well as the expertise of our members who directly reviewed these documents. On Thursday 18th of September 2025 we welcomed eight consumer members to speak directly to two Queensland Health representatives. In that session our members provided extensive verbal advice to Queensland Health representatives who took their own notes. We have written this advice to unpack those views in more detail and context, as well as others that were outside the time-limit of our session. We thank Queensland Health for coming to visit our members directly.

Our focus: Key areas for reform

We provide advice relating to the:

- Policy implications of the "where safe and possible" limitation
- Need to acknowledge harm of restrictive practices
- Importance of a clear rationale and case for change
- Human rights implications and shortcomings in the policies
- Importance of peer support workers and their role in culture-change on restrictive practices
- Making information more accessible
- Family and carer information gaps
- Importance of Queensland Health setting key performance indicators and accountability mechanisms
- Importance of transparency and accessibility of Action Plans

Advice on these areas is provided below.

'Where safe and possible'

The HSD (Attachment 1) and HSD Guideline (Attachment 2) make a condition that HHS only need to enable the reduction and elimination of restrictive practices 'where

safe and possible'. These terms are undefined in the HSD or HSD Guideline. There are many issues with this approach, including:

- **Vague and inconsistent:** The terms used are vague and discretionary, giving existing leaders and clinicians almost complete control over decisions. This leads to poor and inconsistent outcomes, causing unfairness across different regions.
- **Conflicts with "last resort" standard:** This approach effectively turns the nationally recognised "last resort" standard for restrictive practices into a first option.
- **Not aligned with human rights:** It is inconsistent with international human rights standards and with Section 13 of the *Human Rights Act 2019* (Qld) [4].
- **Ignores harm and unsafety:** The approach fails to adequately account for the physical harm and unsafety[5], including death[6], that can arise from the use of restrictive practices[7].
- **Limits elimination and reduction efforts:** Instead of placing limitations on the use of restrictive practices, the approach limits efforts to reduce and eliminate them. This wording inadvertently expends permission for restrictive practices, rather than limiting them.
- **Creates false binary:** It creates a false conflict between staff and consumer safety, even though evidence shows that reducing restrictive practices improves overall safety[8].

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[4] Although the HSD is not the source of the authority to use restrictive practices – these are found under different legislative frameworks – the standard used here is inconsistent with the limitations clause under section 13 of the *Human Rights Act 2019* (Qld). Section 13 provides the lawful basis for legislation, policy decisions or individual decisions to limit human rights. Importantly, this limitation presumes the full enjoyment of human rights subject to limitations. By contrast, this approach puts the limitations on efforts to *protect human rights* through elimination and reduction efforts.

[5] Diana Rose et al, 'Service User Perspectives on Coercion and Restraint in Mental Health' (2017) 14(3) *BJPsych international* 59.

[6] Xenia AK Kersting, Sophie Hirsch and Tilman Steinert, 'Physical Harm and Death in the Context of Coercive Measures in Psychiatric Patients: A Systematic Review' (2019) 10 *Frontiers in psychiatry* 400 ('Physical Harm and Death in the Context of Coercive Measures in Psychiatric Patients').

[7] We acknowledge that the document briefly acknowledges harms, but this centres the concern for safety very clearly on others such as staff.

[8] Kristel Ward-Stockham et al, 'Effect of Safewards on Reducing Conflict and Containment and the Experiences of Staff and Consumers: A Mixed-methods Systematic Review' (2022) 31(1) *International journal of mental health nursing* 199; Lisa M Brophy et al, 'Consumers and Their Supporters' Perspectives on Poor Practice and the Use of Seclusion and Restraint in Mental Health Settings: Results from Australian Focus Groups' (2016) 10(1) *International journal of mental health systems* 1.

- **Hinders organisational learning:** The approach hinders organisational learning and quality improvement by allowing services to continue current practices without exploring safer, non-coercive alternatives.

By granting HHS's unchecked authority to self-determine when seclusion and restraint is 'safe and possible', this approach risks undermining accountability, making restrictive practices as a first resort rather than last-resort, and lead to inequitable outcomes across the state. Where any limitations should be placed, they should be placed on the *use* of restrictive practices, not on the attempts *reduce and eliminate* these harmful practices.

Recommendation 1.1 – Remove 'where safe and possible'

Queensland Health should remove the terms 'where safe and possible' from the HSD and broader policy.

Recommendation 1.2 – Safe should be defined under the policy

Queensland Health should, where "safe" is used in the HSD and broader policy, define safety to include a lived experienced focused definition that includes cultural and other forms of safety.

Naming the harm: Why restrictive practices must end

Queensland Health has the opportunity to create transformative policy that confronts historical and ongoing harm from restrictive practices. Unfortunately, the HSD fails to clearly acknowledge the harm caused by restrictive practices. While the HSD Guideline (Attachment 2) includes a "harm reduction" section that notes the potential harm to patients, families, and staff, these acknowledgements are not central to the document nor are they reflective of the broad and significant known harms.

The failure to adequately acknowledge or defined harm undermines the HSD and the broader policy to eliminate and reduce restrictive practices. While our members identify harm in many different ways, we highlight the following harms:

- Physical health harms arising from the use of involuntary medications used during chemical restraint[9].
- Loss of trust in mental health systems and the openness to seek support in the future, giving fewer options when someone is in distress.
- Physical injuries, including death[10].
- Reinforce intersectional experiences of marginalisation, such as of colonisation or racism.
- A violation of human rights and dignity[11] and constitutes torture[12].

As one of our members said in *Shining a Light*:

> 'I experienced restraint, confinement, and coercive control. These experiences often led to more trauma, unbelievable debilitating side effects and loss of quality of life.'[13]

Institutionalisation causes deep harm—affecting our bodies, minds, relationships, and even future generations[14]. We also note that families, carers, supporters and kin experience vicarious trauma from observing these practices and the harm to someone they care about[15]. Failing to acknowledge harm undermines the intent of the HSD and associated policies. Our members reminded us that the failure to

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[9] Kate Dorozenko and Robyn Martin, *A Critical Literature Review of the Direct, Adverse Effects of Neuroleptics* (National Mental Health Consumer and Carer Forum, 2017) <https://nmhccf.org.au/our-work/nmhccf-library/a-critical-literature-review-of-the-direct-adverse-effects-of-neuroleptics/download>; Timothy Wand, 'Examining the Long-Term Impacts of Psychotropic Drugs and Considerations for People Discontinuing Treatment' (2025) 46(5) *Issues in Mental Health Nursing* 411.

[10] Kersting, Hirsch and Steinert (n 6).

[11] Simon Katterl et al, *Not before Time: Lived Experience-Led Justice and Repair (Advice to the Victorian Mental Health Minister)* (January 2023) <https://static1.squarespace.com/static/64509ef54c074f6f4dfb7138/t/648ed6db5216c12186d165f3/1687082792810/Not+Before+Time+-+State+Acknowledgement+of+Harm+2023+FINAL+ADVICE.pdf>; Committee on the Rights of Persons with Disabilities (n 3) 1; World Health Organization, *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023) <https://www.who.int/publications/i/item/9789240080737>.

[12] United Nations Human Rights Council, Torture and ill-treatment in healthcare settings (A/HRC/22/53, 1 February 2013), 32.

[13] Mental Health Lived Experience Peak Queensland, *Shining a Light: Eliminating Coercive Practices in Queensland Mental Health Services* (2023) 13 <https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf>.

[14] Ibid 38.

[15] Katterl et al (n 11) 6, 13, 23, 24.

adequately acknowledge harm reinforces the 'epistemic injustice' faced by people with lived experience, whose world view and knowledge is routinely marginalised.

These documents and the broader policy should more clearly reflect the harms described by people with lived experience. Doing so will ensure that people's experiences are better reflected in the HSD and that it is better placed to eliminate and reduce these practices. This harm should be acknowledged throughout the document, including at the beginning where readers are most likely to engage with the content.

Recommendation 2.0 – Better acknowledge harm

Queensland Health should:

- amend the HSD and associated documents so that there is greater recognition of the significant harms associated with restrictive practices at both an individual and systemic level, and
- acknowledge this harm *throughout* the HSD and associated documents, including at the beginning of the document.

Creating a case for change

A compelling and clear case for change is a powerful tool to unite Queensland Health, people with lived experience, and the sector in a shared mission. The HSD, HSD Guideline and HSD Participant Information Sheets do not make a clear case for why restrictive practices require elimination. Moreover, it does not demonstrate why this HSD is warranted in service of elimination. The "Purpose" of the HSD states:

> 'Restrictive Practices are practices or interventions used to respond to a person's behaviour that have the effect of restricting a person's rights or freedom of movement and are primarily used for the purpose of preventing serious, imminent physical and psychological harm to that person or others (Restrictive Practices).
>
> The purpose of this Health Service Directive (HSD) is to:
>
> - provide principles for the use of Restrictive Practices;

- enable the reduction and elimination of Restrictive Practices, where safe and possible; and
- require monitoring and reporting of the use of Restrictive Practices.

This HSD is inclusive of all practices or interventions used to respond to people of all ages, including children and young people.'

The policy document's main objective—to reduce and eliminate restrictive practices—is ineffective because it's obscured. This primary goal is buried in the second bullet point, overshadowed by less relevant, and even contradictory, information. For example, it's confusing to create a policy to eliminate restrictive practices while also including principles for their use. A successful public policy, especially one based on lived experience[16], requires a clear vision of the future state, the problem and what actions are needed.

The HSD and associated documents would benefit from a clear rationale for:

- what kind of health and mental health system we should all should enjoy
- how restrictive practices are a problem we all seek to resolve
- why elimination and reduction are necessary
- the current barriers to eliminating and reducing strictive practices[17], and
- why this HSD is necessary for elimination and reduction.

MHLEPQ members have advised Queensland Health some of the reasons why elimination is needed is because:

- Restrictive practices are a human rights violation
- Restrictive practices cause significant harm
- People with lived experience will feel safer to ask for help
- People with lived experience will have more trust in the mental health system.

[16] Simon Katterl and Kathy Wilson, *Mental Health Policy Grounded in Consumer Perspectives*: *A Model for In-Community Policy Development* (Simon Katterl Consulting & Kathy Wilson Consulting, 2025) <https://www.simonkatterlconsulting.com/writing/public-policy-resources>.

[17] These include the barriers identified by our members, including power imbalances, epistemic injustice, a lack of legal redress and more.

To achieve a clear, shared case for change, Queensland Health, people with lived experience, and the sector need to rewrite the HSD Participant Information Sheets. Currently, these sheets appear to justify and explain the use of restrictive practices, rather than serving as a tool for people to understand their rights and drive the reduction and elimination of these practices[18]. People with lived experience have an important role in regulating and eliminating the use of restrictive practices[19]. This requires Queensland Health to more clearly identify what role people with lived experience play in driving elimination and reduction of restrictive practices so that information sheets help them to fulfill this role.

Recommendation 3.1 – Articulate the case for change

Queensland Health should amend the HSD and associated documents to make clear the case for why restrictive practices must be eliminated and why these policies are necessary.

Recommendation 3.2 – Rewrite HSD Patient Information Sheets

Queensland Health should rewrite the HSD Patient Information Sheets to more clearly serve the policy purpose of eliminating and reducing restrictive practices.

Better aligning the HSD with human rights

By aligning the HSD with human rights, Queensland Health can create a powerful and just framework that positions individuals as rights-bearers rather than objects of medical intervention. Alignment of the HSD with human rights gives the policy a far greater prospect of success by placing the person at the centre of policy-making and helping navigate complex issues around shared safety and diverse interests[20].

[18] For example elimination and reduction is only mentioned in the second last section of the Chemical Restraint Patient Information Sheet.

[19] Simon Katterl and Sharon Friel, 'Regulating Rights: Developing a Human Rights and Mental Health Regulatory Framework' in Kay Wilson, Yvette Maker and Piers Gooding (eds), *The Future of Mental Health, Disability and Criminal Law* (Routledge, 2023) 267.

[20] Simon Katterl and Kerin Leonard, *Putting Human Rights at the Heart*: *Thinking about Human Rights* (Simon Katterl Consulting & Lionheart Consulting Australia, August 2023) <https://www.simonkatterlconsulting.com/writing/launch-of-new-resources-putting-human-rights-at-the-heart>.Queensland Human Rights Commission, *Human Rights Act 2019*: *A Guide for Public Entities* (Queensland Human Rights Commission, 2019).

We are concerned that the HSD and the broader policy doesn't adequately align with human rights.

We advocate for the complete abolition of restrictive practices, including involuntary mental health treatment[21]. This is a stance shaped by lived experience and the success within Queensland[22] other jurisdictions that have moved toward this goal[23]. Some HHSs have shown that it's possible to operate for years without seclusion events, demonstrating a clear path forward. The current inability to effectively monitor these practices is worsened by the lack of a designated Queensland National Preventive Mechanism[24], a body that would monitor detention places under international human rights treaties.

Under the *Human Rights Act 2019* (Qld), Queensland Health has a legal and ethical duty to ensure its policies, including the HSD, uphold human rights. This means any limitation on a person's rights, such as those imposed by restrictive practices, must be demonstrably justified. The HSD, however, has significant shortcomings. It misidentifies the rights at stake, incorrectly focusing on "freedom of movement" rather than the more relevant rights detailed in Appendix 1.

The HSD and policy framework would benefit from a deeper human rights analysis and review. This analysis and review should:

- Clearly and accurately identify which rights are engaged and how
- Demonstrate what steps are taken to protect those rights
- Better contributes the elimination of restrictive practices in line with international and Queensland human rights law.

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[21] Mental Health Lived Experience Peak Queensland (n 13).

[22] Nathan Gibson et al, *Mental Health Act 2016 Report: Review into the use of Seclusion, Mechanical Restraint and Physical Restraint under the Queensland Mental Health Act 2016* (Report, State of Queensland (Queensland Health), March 2023).

[23] For example, the *Mental Health and Wellbeing Act 2022* (Vic) has legislated the objective to eliminate restrictive practices: *Mental Health and Wellbeing Act 2022* (Vic), s 125.

[24] Two pieces of legislation – Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Act 2022 (Qld) and *Inspector of Detention Services Act 2022* (Qld) – authorise international inspections from the UN Subcommittee on the Prevention of Torture, but have not established the routine domestic mechanism to monitor places of detention.

Rewriting the paragraph within the human rights section would not be sufficient to address these issues.

Beyond this, we recommend that Queensland Health urgently commission independent advice on how to proactively embed human rights into stewardship of the mental health system. Gaps in the HSD reflect existing issues seen elsewhere in implementing human rights[25]. The advice should be co-led by people with lived experience, including the lived and living experience workforce, to make practical human rights in Queensland mental health policy.

Recommendation 4.1 – Review and revise for human rights

Queensland Health should review and revise the HSD and associated documents based on human rights.

Queensland Health should separately indicate a timeline on the appointment of the Queensland National Preventive Mechanism due to monitor closed environments such as those using restrictive practices.

Recommendation 4.2 – Commission advice on human rights

Queensland Health should commission advice – co-led by people with lived experience – on implementing human rights across Queensland mental health policy.

Preventing unintended consequences

Clear and unambiguous language is crucial for preventing the unintended expansion of restrictive practices, and Queensland Health can strengthen the HSD by ensuring all legal frameworks are harmonised. The HSD, HSD Guideline and HSD Participant Information sheets engage are challenged by multiple laws permitting the use of restrictive practices.

[25] Simon Katterl and Chris Maylea, 'Keeping Human Rights in Mind: Embedding the Victorian Charter of Human Rights into the Public Mental Health System' (2021) 27(1) *Australian Journal of Human Rights* 58.

MHLEPQ members have identified potential inconsistencies between the *Mental Health Act 2016* (Qld), the Chief Psychiatrist guidelines authorising restrictive practices, and the HSD Chemical Restraint Participant Information Sheet. The latter identifies where compulsory medication is permitted, but does not indicate where it is not authorised. This may lead to instances where readers, including clinicians, are unclear on the circumstances where their use of involuntary medication is unlawful. This may expand the number of instances where chemical restraint is used. Clarifying this, perhaps with a non-exhaustive list of circumstances where it cannot be used, may assist.

Recommendation 5.0 – Clarify unlawful use of compulsory medications

Queensland Health should amend the HSD Chemical Restraint Participant Information Sheet to clarify when use of compulsory medications could be considered chemical restraint, and therefore unlawful.

The importance of peer support workers and documentation

Peer support workers are crucial for preventing and responding to restrictive practices. In preventing the use of restrictive practices, peer support workers are known to have more relational and less restrictive approaches to responding to distress[26]. Ensuring peers are in leadership positions can create less restrictive environments and also ensure debriefing and quality improvement processes seek to avoid restrictive practices in the future. Including information on peer support workers, other lived experience workforce members, and independent patients' rights advisors in the HSD, HSD Guideline, and HSD Participant Information Sheets would create better ways to prevent and respond to restrictive practices.

[26] Queensland Health, *Lived Experience (Peer) Workforce Framework* (Queensland Health, 2023) <https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf>; Hamilton Kennedy et al, 'Consumer Recommendations for Enhancing the Safewards Model and Interventions' (2019) 28(2) *International Journal of Mental Health Nursing* 616.

Recommendation 6.0 – Include peer support workers and others

Queensland Health should better articulate the role of peer support workers, lived experience workers, and independent patients' rights advisers.

Making the resources more accessible

Accessible information in people's preferred languages ensures that all community members can participate in elimination and reduction practices. Our members noted that the HSD and associated documents are heavily reliant on written text and very little is communicated through visuals. We also noted that these information sheets are available in other languages. This impairs the ability of our diverse representative community to participate in elimination and reduction efforts.

Recommendation 7.1 – Utilise visuals

Queensland Health should utilise visuals across the HSD Participant Information Sheets for greater clarity.

Recommendation 7.2 – Multiple languages

Queensland Health should ensure that these HSD Participant Information Sheets are available in multiple languages.

Family and carer information gaps

Queensland Health can improve the HSD by providing resources that enable a person's chosen family, carer, or kin to advocate for them and uphold their rights. MHLEPQ members have differing experiences of family members[27]. For many people with lived experience subject to restrictive practices, their family of choice is the advocate to prevent or stop the use of restrictive practices.

There are no HSD Participant Information Sheets that assist a family, carer supporter or kin to support someone who may, is experiencing, or has experienced a restrictive

[27] Some family members are the source of mental health support while others are the source of trauma and coercion.

practice. A HSD Family Information Sheet with the expressed purpose of supporting the rights of a person with lived experience regarding restrictive practices may assist. This approach should uphold all existing human rights, including privacy rights, of people with lived experience.

Recommendation 8.0 – Create a HSD family information sheet

Queensland Health should consider the development of a HSD family-carer information sheet.

Setting the standards

By assuming the role of system steward and setting clear standards, Queensland Health can ensure consistency and accountability across all HHSs. The current HSD and HSD Guideline give HHSs the authority to set their own objectives, targets, and key performance indicators (KPIs). At the MHLEPQ, we believe Queensland Health, not the HHS, should be responsible for setting these objectives, targets, and KPIs. This is the Queensland Government's existing policy approach[28]. In the alternative, there must be a mandated responsibility to publicly co-design these KPIs with people with lived experience (particularly of restrictive practices). Queensland Health either needs to set centralised standards with devolved mechanisms to deliver them, or in the extraordinary circumstances that HHSs would be permitted to set their own standards, those standards are meaningfully co-designed with people with lived experience.

[28] The Queensland Government has stated that the Queensland Government sets policy, targets and standards, whereas services are then given autonomy to achieve those requirements: Queensland Health, *Performance and Accountability Framework*: *Effective from 1 July 2025* (Queensland Government, July 2025), 6.

Recommendation 9.1 – Queensland Health set objectives and KPIs

Queensland Health should assume the role of system steward and set the objectives and KPIs for HHS, devolving authority for them to develop an action-plan to achieve those objectives and KPIs.

Recommendation 9.2 Queensland Health mandates co-design

In the alternative, Queensland Health should amend the HSD to mandate co-design with people with lived experience to develop those objectives, KPIs and actions at a local HHS level.

Engagement with lived experience

Meaningful engagement with people who have lived experience is essential for developing a truly effective HSD imposed action plan that reflects the needs and perspectives of those it aims to serve. The HSD Guideline states that the Action Plan should be developed in consultation with key stakeholders including consumer and carer representatives. This is optional rather than mandatory as it is not in the HSD. Our members formed the strong view that engagement with people with lived experience should be mandatory. This should include engagement with peer workers (recommendation 6.0). That engagement should be with a broad range of people with lived experience, First Nations communities, and families who are supportive of elimination of restrictive practices.

As such, the HSD should be amended to include the requirement to engage people with lived experience. The wording – currently in the HSD Guideline – should also shift from "may" to "must", to indicate the mandatory nature of this component. The HSD should clearly articulate where and how that engagement should occur.

Recommendation 10.0 – Mandated lived experience engagement

Queensland Health should amend the HSD to include a requirement to engagement people with lived experience, with appropriate HSD Guidance material on how to adequately do so.

Embedding accountability

To ensure the policy's success and protect human rights, clear and enforceable accountability mechanisms are necessary to hold all parties responsible. The HSD requires HHSs to comply with it but does not specify what actions Queensland Health or the Minister may take in cases of non-compliance. In effect, this means that it is not clear what happens where HHSs choose not to develop action plans or fail to pursue or achieve the actions within those plans.

MHLEPQ strongly believes that the lack of adequate enforcement body undermines human rights protection[29] and any HSD. The Queensland Government, including Queensland Health and the Health Minister, contain the following powers to:

- Direct the HHS Board[30]
- Remove Board members for non-compliance or systemic failure[31]
- Appoint advisers[32] and auditors[33]
- Report non-compliance to Parliament

MHLEPQ also notes that the Chief Psychiatrist reports on instances of non-compliance that it identifies as part of its annual reporting, identifying over 300 instances of non-compliance[34]. Our members have mixed views about exactly how

[29] Mental Health Lived Experience Peak Queensland, *First Review of the Queensland Human Rights Act 2019* (Mental Health Lived Experience Peak Queensland, June 2024) 24–25 <https://mhlepq.org.au/wp-content/uploads/2024/07/MHLEPQ-Submission-to-the-Qld-Human-Rights-Act-Review-FINAL.pdf>.

[30] *Hospital and Health Services Act 2011* (Qld) s 44.

[31] *Hospital and Health Services Act 2011* (Qld) s 28.

[32] *Hospital and Health Services Act 2011* (Qld) s 44A to 44E.

[33] *Hospital and Health Services Act 2011* (Qld) s 56.

[34] *Chief Psychiatrist annual report 2023-2024* (Annual Report, 2024) 11 < https://www.health.qld.gov.au/__data/assets/pdf_file/0032/1364954/Chief-Psychiatrist-Annual-Report-2023-2024.PDF>

accountability should be established. Some favour public Parliamentary reporting processes, while others expressed hesitancy about the politicising impact of these processes. At MHLEPQ we are clear that it is not sufficient to state that compliance is responsibility of the HHS, when we are aware that breaches of rights are common. The HSD should be amended to more clearly state what actions Queensland Health, and the Minister will take to prevent non-compliance, and what it will do when it becomes aware of a failure to implement an action plan.

Recommendation 11.0 – Outline accountability and compliance

Queensland Health should amend the HSD to clearly outline what preventative steps Queensland Health will take to support compliance with the HSD, and what actions it may take for instances of non-compliance with the HSD by HHSs.

Making the action plans available

Transparency is key to building trust and ensuring the HSD's effectiveness, and making action plans publicly available is a critical step toward this goal. The HSD Guideline states that the action plan 'should be shared across the HHS with all relevant stakeholders including patients, to support transparency and accountability.' This is included in the HSD Guideline but not in the HSD, meaning it is optional to HHS to do so.

Our members have identified that there are many instances where people with lived experience are not given information on their rights. This is compounded by the fact that notes are often not collaboratively written, meaning justifications for the use of restrictive practices can be untrue, harmful and miss the opportunity to prevent future use of restrictive practices through quality improvement. These barriers lead to justified scepticism that this action plan will be shared adequately, or that the information that is reported against that action plan will be accurate.

Further work needs to be done to make these action plans available. Disclosure of these action plans should not be left to the discretion of the HHS. This will undermine trust in these processes and create inequities across different HHS's.

Recommendation 12.0 – Mandate public disclosure

Queensland Health should amend the HSD to make clear that HHS's must make their action plan publicly available and available to people with lived experience.

MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK
QUEENSLAND

Who are MHLEPQ?

Established in July 2021, the Mental Health Lived Experience Peak Queensland **(MHLEPQ)** is an organisation with almost 600 members across the state. We provide advice and advocacy on Queensland's mental health system, with a specific focus on supporting those who are socially disadvantaged and marginalised.

We are primarily funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health, and have been directly contracting with Queensland Health since 1 January 2023. Our work is guided by the principles of equity, access, cultural safety, recovery, and human rights.

The MHLEPQ's work spans across multiple areas, from a variety of projects and policy areas, including:

- The Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement
- The Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care
- Implementation of Human Rights in the Queensland Mental Health System
- Research, consultation and thought leadership on Psychosocial Hazards in the Lived Experience (Peer) Workforce Elimination of the Use of Seclusion and Restraints Show more.

MHLEPQ is also a governing member of the National Mental Health Consumer Alliance (**NMHCA**). The NMHCA brings together other state and territory consumer peak bodies to collaborate and coordinate on shared issues, including those related to Commonwealth policy and government-funded services.

Further contact

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Appendix 1: Better complying with human rights

MHLEPQ highlights the importance of aligning this policy with Queensland Health's duties under section 58 of the *Human Rights Act 2019* (Qld). When introducing the *Human Rights Bill 2019* to Parliament, Attorney-General and Minister for Justice Yvette D'ath stated that it would 'ensure that human rights are a key consideration in public sector decision-making and in the development of policy and legislation in Queensland.'[35] Putting human rights at the heart of public sector decision making is a positive and can:

- **Better outcomes:** drive better outcomes for people, as it frames individuals as rights-bearers rather than objects of charity or medical intervention.
- **Reframe problems:** provide a new thinking tool for re-analysing problems as rights violations, which should not be tolerated and must be addressed. It focuses on respecting rights and holding duty bearers accountable.
- **Navigate complexity:** help public sector staff to navigate complex work where there are competing needs and perspectives.
- **Supporting equity:** help policies meet the needs of marginalised groups who have traditionally faced discrimination[36].

Section 58 places this duty on public entities, including Queensland Health, to properly consider and comply with relevant human rights. Victorian[37], ACT and Queensland[38] case law has re-affirmed the nature and scope of these duties. Section 13 provides the circumstances in which rights can be lawfully limited either through

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[35] Queensland, Parliamentary Debates, Legislative Assembly, Second Reading, 26 February 2019, 376 (Yvette D'Ath, Attorney-General and Minister for Justice).

[36] Katterl and Leonard (n 19).Queensland Human Rights Commission, *Human Rights Act 2019: A Guide for Public Entities* (Queensland Human Rights Commission, 2019).

[37] *Castles v Secretary to the Department of Justice* [2010] VSC 310; *Bare v Independent Broad-based Anti-corruption Commission* [2012] VSCA 197; *Certain Children v Minister for Families and Children* [2017] VSC 251.

[38] *Owen-D'Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273; Johnston v Commissioner of Police [2024] QSC 2.

legislation passed by Parliament or through decisions by public entities. Section 13(2) requires that any limitation on rights is considered justifiable based on the following factors:

- The nature of the human right (the seriousness of the right)
- The purpose of the limitation (the rationale)
- The importance of the purpose (whether the rationale is compelling)
- The relationship between the limitation and purpose (whether the limitation on rights achieves the purpose)
- Whether there are any less restrictive and reasonably available ways to achieve the purpose (whether it is proportionate)
- The importance of preserving the human right, taking into account the nature and extent of the limitation of the human right (the more it restricts the more compelling it should be).

The HSD and its associated documents should be understood as part of the Queensland Health's ongoing requirement to ensure that human rights are upheld and only limited in ways consistent with section 13.

Doing so in this policy requires that Queensland Health understand what the objective of the policy is that it is undertaking and applying a human rights analysis. In this case, Queensland Health seeks to eliminate and reduce restrictive practices in mental health settings. Queensland Health then must identify the relevant rights that are limited and breached by the use of seclusion and restraint, and design a policy that is responsive to those circumstances. Firstly, the policy should demonstrate what rights have been engaged and how. Secondly, it should take proactive steps to ensure that any use of seclusion and restraint can only be justified with reference to this policy in ways that are consistent with section 13.

Human rights and restrictive practices

The following rights are engaged by restrictive practices:

- Right to liberty and security of person
- Protection from torture and cruel, inhuman or degrading treatment
- Recognition and equality before the law
- Humane treatment when deprived of liberty
- Rights of children
- Right to privacy
- Cultural rights (general and Aboriginal and Torres Strait Islanders).

The enormous variance between HHS's, whereby some services have come close to eliminating practices for an extended period, is suggestive that services are not properly considering and complying with these rights equally.

The HSD does not adequately align with the human rights of people with lived experience of restrictive practices. Under "Human rights" the HSD states:

> 'Restrictive Practices involve restriction of an individual's human rights, including but not limited to, freedom of movement. This Health Service Directive and associated Guideline aligns with Queensland Health's commitment to promoting, protecting and, ensuring the full and equal enjoyment of all human rights, fundamental freedoms and, dignity of persons. It aims to limit any reasonable and justifiable restrictions which may be placed on a person's human rights by the use of Restrictive Practices, consistent with the intent and purpose of the *Human Rights Act 2019* (Qld).'

This contains errors and omissions. Freedom of movement is not engaged by this policy, as it does not relate to where someone lives and their ability to enter-and-leave Queensland[39]. There are also significant rights limitations and breaches that are not acknowledged to the above-mentioned human rights. The failure to adequately consider these rights and proactively address these issues through the HSD means unlawful use of restrictive practices remains unaddressed in this HSD.

[39] 'Freedom of Movement' <https://www.qhrc.qld.gov.au/your-rights/human-rights-law/freedom-of-movement> The restriction of bodily movements is better characterised as a restriction on the right to privacy (bodily integrity), the right to protection from torture and cruel, inhuman or degrading treatment, and the right to liberty and security of person.

This undermines the policy's stated intent to eliminate and reduce restrictive practices. The text also fails to provide any account of how human rights are protected through the policy and the actions taken by Queensland Health.

The HSD and policy framework would benefit from a deeper human rights analysis and review. This analysis and review should:

- Clearly and accurately identify which rights are engaged and how
- Demonstrate what steps are taken to protect those rights
- Better contributes the elimination of restrictive practices in line with international and Queensland human rights law.

Rewriting the paragraph within the human rights section would not be sufficient to address these issues.