Survey Response

1. **Which WPA Member Society or Association do you represent?**
   The Royal Australian and New Zealand College of Psychiatrists.

2. **Does your Member Society/Association have an Alternatives to Coercion (or similar) leadership group to expedite discussion and action in your country/region?**
   The RANZCP’s Position statement 61: Minimising and where possible eliminating the use of seclusion and restraint in people with mental illness was led by the Committee for Professional Practice and approved by the RANZCP Board. The RANZCP does not currently have a formal group with specific responsibility for alternatives to coercion.

3. **The WPA Position Statement notes widespread agreement that coercion is overused in mental health systems all around the world. Are there any steps being taken in your country or region to address this situation?**
   In Australia, the responsibility of restrictive practices sits with the states and territory jurisdictions that are primarily responsible for the funding and operation of acute mental healthcare and hospitals. Mental health legislation that governs involuntary treatment also exists in the state and territory governments rather than the federal government.

   The RANZCP urges all state and territory governments to work towards the minimisation and where possible elimination of restrictive practices. The RANZCP has published Position statement 61: Minimising and where possible eliminating the use of seclusion and restraint in people with mental illness. This document has been developed to guide psychiatrists and others in the mental health sector in minimising and where possible eliminating seclusion and restraint. Separately, the Australian and New Zealand College of Anaesthetists has developed Guidelines for safe care for patients sedated in health care facilities for acute behavioural disturbance (ABD). The document sets the minimum safety standards required in caring for patients with ABD where sedation is used to control the behaviour.

   The elimination of seclusion in mental health has been the policy of the New Zealand government for over a decade. In 2020 the New Zealand Human Rights Commission published a report on the practice of seclusion and restraint in New Zealand. The report made a range of recommendations to Oranga Tamariki (New Zealand Ministry for Children), the Ministry of Health and the District Health Boards and the Department of Corrections. The New Zealand Government is currently working towards the elimination of seclusion and restraint through the Zero seclusion: Safety and dignity for all project which is managed by the Health Quality& Safety Commission of New Zealand.

   The different the RANZCP requested that the Queensland parliamentary Select Committee on Mental Health review the Locked Wards policy in Queensland as part of the Parliamentary Inquiry into Mental Health Services in Queensland. As part of the review of the Health and Wellbeing Act in Victoria, seclusion and restraint has been a focus and engagement with consumer associations as well as the RANZCP has occurred and will be a major priority of the Act’s implementation.

   Reviews of the Mental Health legislation across a number of jurisdictions including Western Australia and South Australia are also underway.
The Australian Institute of Health and Welfare (AIHW) reports on restrictive practice in mental health care to monitor and influence practice.

4. **Have members of your Society/Association taken any steps to implement alternatives to coercion and ensure that mental health treatment and care upholds the human rights of people with psychosocial disabilities? Please describe.**

RANZCP members work with governments to ensure the treatment of those with psychological disabilities upholds their human rights and that coercion is only ever used as a last resort. For example, *The Royal Commission into Victoria’s Mental Health System* (Victorian State Government review into its mental health system) contains specific recommendations relating to coercion and restraint which RANZCP members are involved in Implementing (see recommendations 42, 53 and 54).

5. **What do you see as the next steps for your Society/Association in supporting alternatives to coercion in mental health care?**

The RANZCP intends to continue our advocacy to minimise and where possible eliminate restrictive practices.

Our most recent advocacy in this area was in our submission to the Royal College of General Practitioners Standards for Healthcare in Australian Prisons submission. In the submission, we reiterated that seclusion and restraint should never be used to control behaviour, as a punishment or because of inadequate resources and only used as a last resort. We have provided a submission against solutions for the use of chemical restraints in aged care which would have had unintended consequences for the necessary prescribing of antipsychotics. The RANZCP has also provided feedback to the New Zealand government to improve the Mental Health (Compulsory Assessment and Treatment) Bill 2021.

6. **Delivery of Treatment: Please consider the recommendations from the WPA regarding delivery of treatment and care on page 5 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?**

RANZCP members have found the main means of avoiding coercive measures involve the ready availability of a combination of authoritative advice, appropriately trained and acculturated staff and a level of staffing that is capable of achieving the avoidance of coercive measures. Continued advocacy by the WPA remains its most important service. Part of this advocacy should include acknowledging and promoting work done by psychiatrists in the field. Advocacy should focus on systems change and empowering psychiatrists to implement alternatives to coercion while ensuring occupational safety while recognising that elimination may not be possible in all services.

7. **Policy: Please consider the recommendations from the WPA regarding policy on pages 5-6 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?**

The RANZCP believes caution should be exercised regarding the use of levels of coercion as a performance indicator. Psychiatrists needing to resort to coercive practices may be an indicator of unmet need in relation to service provision.

8. **Service Culture: Please consider the following recommendations from the WPA regarding service culture on page 6 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?**
The implementation of recovery-oriented models of care underpins the cultural changes necessary to minimise and where possible eliminate the use of restrictive practices. Recovery-oriented models of care have the potential to reduce the stigma against people with mental health conditions and encourage a culture of participation and patient autonomy. The RANZCP believes the WPA should advocate and provide tools and resources to help practices implement recovery-oriented models of care to assist in creating cultural changes necessary to minimise and where possible eliminate restrictive practices.

WPA advocacy should also acknowledge the role of cultural bias and institutional racism in the use of seclusion and restraint. The WPA could provide resources and education on cultural bias and institutional racism to ensure restrictive practices are not used in a manner that is discriminatory.

9. **Research:** Please consider the following recommendations from the WPA regarding research on pages 6-7 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?

The RANZCP believes any research programs established that work towards minimising and where possible, eliminating restrictive practices should be long-term in nature. The RANZCP encourages the WPA to focus on supporting long-term research to produce high-quality research findings that support best practice in minimising and where possible eliminating restrictive practice.

10. **Does your society work with service users or advocacy groups for people with mental ill-health and/or psychosocial disabilities?** If so, can you please describe this work? If there are any weblinks to descriptions of this work, or resources to support it we would appreciate it if you could share them here.

The RANZCP prioritises the views of people with lived experience in its advocacy. For a consultation with the lived experience community, the RANZCP principally consults with the **Community Collaboration Committee (CCC)**. The CCC is made up of six RANZCP Fellows (psychiatrists) and eight community members: two carers and two consumers from Australia, and two carers and two consumers from New Zealand. The CCC meets regularly throughout the year. A member of the lived experience community also sits on the New Zealand National Committee. If wider consultation is required, the RANZCP has a working relationship with Lived Experience Australia and can undertake more substantial consultation with the Australian lived experience community. A key document that has been produced by CCC is **Position statement 62: Partnering people with lived experience**. This document outlines the importance of working with people with lived experience and will be helpful in working towards the WPA’s goals.

11. **Does your society work with family members of service users and, if so, can you please describe this work?** If there are any weblinks to descriptions of this work, or resources to support it we would appreciate it if you could share them here.

The RANZCP’s CCC is the College’s Committee that provides the views of people with lived experience. The RANZCP also has an **Aboriginal and Torres Strait Islander Mental Health Committee** and **Te Kaunihera** who represent Māori in New Zealand. For indigenous people, family can have differing and broader meanings than western definitions of family such as the concept of whānau, a wider definition of family used by Māori. The RANZCP also engages with families and whānau by publishing information about mental health on our **Your Health in Mind** website including information on admission to psychiatric hospitals and the use of restrictive practice. This website is designed to be more accessible to the general public and uses language that is more easily understood to discuss mental health and help families understand what their loved one is going through.
12. Do the countries in your jurisdiction have public databases that record the frequency and duration of seclusion and restraint? If so, how can we access the database(s)? Please list databases with a brief summary of what information can be accessed there and weblinks as relevant.

National data on seclusion and restraint in Australia is held by the AIHW. The AIHW collects data from all Australian states and territories and provides analysis. New Zealand does not currently have a database but the New Zealand Human Rights Commission has reported data on seclusions and restraint.

13. Is there anything else you would like to tell us about Implementing Alternatives to Coercion in your country, and/or how the WPA can support the changes described in the Position Statement and Call to Action?

The RANZCP is of the view that there are opportunities for a greater focus on the use of coercive practices in prisons as part of the WPA’s advocacy and resources related to the Position Statement and call to Action. Coercive practices occur regularly against people with severe mental health conditions in Australian and New Zealand prisons. While it is called solitary confinement or segregation it is no less damaging. Such punishment harms prisoners who are not mentally ill and worsens the condition of those who are Segregation is usually used as a disciplinary punishment for sentenced prisoners. It can also be used as a substitute for proper medical or psychiatric care for mentally disordered people.

Future advocacy should also acknowledge that total elimination of restrictive practice may not be possible when treating members of our communities with the most severe mental health conditions. In these instances, a balance must be struck between the rights of healthcare workers and the community to be safe and the patient’s human rights including bodily autonomy.