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MENTAL HEALTH LIVED EXPERIENCE TASMANIA

NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Restrictive Interventions in Mental Health Care:

Tasmania's leading governance and review structure, and the opportunity for national reform.

January 2026

Acknowledgement of Country

Mental Health Lived Experience Tasmania (MHLET) and the National Mental Health Consumer Alliance (Alliance) respectfully acknowledge the original custodians of the lands and seas of Australia, on which we live and work. We pay our respects to elders, past and present.

We acknowledge the significant ongoing and pervasive harmful impacts of colonisation and respect the resilience of First Nation's Peoples and their retained strong connection to Country, culture, and community.

We recognise that sovereignty was never ceded.

This was, is, and will always be Aboriginal Land

About MHLET

MHLET is a not-for-profit organisation dedicated to empowering Tasmanians with lived experience of mental health challenges. By advocating for, and with, Tasmanians, we amplify the voices of people with lived experience to create meaningful systemic change in mental health services for the Tasmanian community.

More information is available on MHLET's website MHLET.org.au

About The Alliance

The Alliance is the national peak body representing mental health consumers. We work together to represent the voice of all mental health consumers on national issues. We are the people experiencing mental health issues/distress; at the table advocating with government and policy makers; and working with a robust network of grassroots communities.

More information is available on the Alliance's website: nmhca.org.au.

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Acknowledgements

MHLET and the Alliance would like to extend their sincere gratitude to the consumer representatives and clinicians who have generously contributed their time, expertise and insights to this paper on seclusion and restraint governance and review structures in Tasmanian mental health care. Their direct contributions are shared throughout this paper in **red** and **blue**, respectively.

We are grateful to the consumer representatives who participated in this project; their candid and insightful contributions have been essential to this work. By sharing their experiences and perspectives as active members within this nation-leading framework, they have been demonstrable in the value of lived experience in mental health care. They illuminated the human impact of these practices and highlighted the crucial importance of centring the voices of those directly affected in governance and review processes. Their insights have ensured that this paper remains grounded and focused on what truly matters: dignity, safety and respect.

We also wish to thank to the clinicians who engaged thoughtfully with our research. Their professional knowledge and clinical experience have been invaluable in helping us understand the complexities of current governance frameworks and the practical challenges of implementing person-centred approaches within these systems. Their willingness to engage critically and constructively with questions about how lived experience can be meaningfully incorporated into review processes demonstrates a genuine commitment to improving practice.

This paper represents a collaborative effort that recognises seclusion and restraint as issues requiring both clinical understanding and lived experience expertise. Such partnership is vital if we are to develop governance frameworks that are genuinely accountable, transparent and responsive to those affected by these practices.

We are deeply appreciative of the time and energy generously given by everyone involved.

We hope this paper will contribute meaningfully to systemic change, ensuring that lived experience becomes integral to how we govern, review and ultimately reduce the use of these practices in mental health care.

Statement on terminology

This paper employs clinical terminology, including terms such as “restrictive interventions”, "mental illness" and "patient", in its examination of mental health care systems in Tasmania. The use of such language reflects the clinical context being analysed and the formal healthcare frameworks under examination.

We acknowledge that these terms may not represent the preferred language of many persons with lived experience of mental health challenges. Many individuals and communities may favour alternative terminology, including person-first and identity-first language that better reflects their values and experiences.

The adoption of clinical terminology in this paper is a deliberate analytical choice to engage directly with the clinical systems, policies, and practices under scrutiny. It is not intended to diminish the agency, identity, or preferences of those with lived experience, nor to endorse these terms as universally appropriate or preferred.

We recognise the importance of language in shaping how mental health is understood and discussed, and we remain committed to respectful, person-centred communication that honours the diverse preferences and perspectives of the communities we represent.

About this paper

This paper emerges from a strategic collaboration between MHLET and the Alliance. Through this partnership, MHLET has spearheaded an initiative to elevate an issue of national significance to the forefront of national discourse and policy development.

The Alliance aims to integrate the findings and insights derived from this project into its national advocacy framework and policy recommendations. Moreover, the Alliance has pledged its commitment to facilitating the outcomes identified as priorities by MHLET, leveraging its organisational capacity and influence to support these objectives.

The collaborative nature of this undertaking showcases the potential of combining authentic lived experience expertise with established national advocacy structures. By harnessing the complementary strengths of both organisations, this project seeks to drive meaningful systemic change and contribute to the evolution of mental health policy and practice at the national level.

EXECUTIVE SUMMARY

A comprehensive examination of Restrictive Interventions in mental health care reveals that Tasmania's governance model represents a national benchmark and should be adopted by all other Australian states and territories to accelerate the collective journey towards reducing and eliminating Restrictive Interventions. This analysis addresses the nature of these interventions, arguments for and against their use, the operational and legal framework within Tasmania, the multi-tiered system of oversight, and critical strengths and challenges, culminating in advocacy for national reform based on the Tasmanian model of lived experience inclusion in governance.

The analysis begins by defining the primary types of Restrictive Interventions (physical, mechanical, chemical, and seclusion) as actions that restrict a person's freedom of movement and are employed as measures of last resort to ensure safety. The justification for continued use, primarily the immediate safety of the individual and others, is weighed against evidence highlighting the profound ethical, physical, and psychological harms these practices inflict, including the erosion of therapeutic trust, the re-traumatisation of vulnerable individuals, and violations of human rights. Consumers and their supporters advocate for the reduction and eventual elimination of Restrictive Interventions, recognising their harmful nature[1,2].

Tasmania's lawful use of Restrictive Interventions is governed by the *Mental Health Act 2013* (Tas), which limits them to individuals who are involuntarily detained at assessment centres[3]. A critical feature of the Tasmanian framework is its adherence to core guiding principles of least restrictive care, trauma-informed practice, dignity, and safety-first, which are operationalised through de-escalation strategies such as the Safewards framework and MAYBO training[4,5].

The cornerstone of the Tasmanian system is its three-tiered oversight and review mechanism. This includes immediate post-event Huddles and Debriefs for staff and consumers respectively, monthly Restrictive Intervention Review Panels at the unit level, and a statewide Seclusion and Restraint Oversight Committee[6,7]. The inclusion of representation from consumers and family & friends at both unit and statewide levels is a nationally distinctive achievement that ensures a focus on systemic accountability, continual learning and development, and upholding individual human dignity.

Direct interviews with both clinicians and consumer representatives who participate at unit or statewide levels of oversight reveal a strong alignment on the strengths of the current governance, such as its multidisciplinary nature and its focus on reflective learning. These interviews also identify shared priorities for improvement, including enhancing the consistency of post-incident debriefs and integrating learning into individual care plans. While clinicians and consumer representatives share the same ultimate goal, their emphases differ, with clinicians focused on processes and data, and consumer representatives on human rights and practical consumer-centred detail. The findings suggest that often the outcome focuses are aligned.

The Tasmanian model of lived experience inclusion in Restrictive Intervention review processes represents a proven, effective, and ethically superior approach. By mandating the inclusion of lived experience at all levels of review, other jurisdictions can replicate Tasmania's success in creating a system that is more transparent, effective, and humane, thereby driving a significant reduction in the use of restrictive practices across the nation.

Introduction

Restrictive Interventions in mental health care present a fundamental ethical paradox: while intended to ensure safety, they conflict with therapeutic principles, human dignity, and recovery-oriented practice. This tension between immediate risk management and long-term wellbeing has prompted calls for systemic reform across Australia.

Practices utilising restraint (physical, mechanical, or chemical) and seclusion are profound infringements on personal liberty with potentially lasting psychological consequences, fundamentally compromising the therapeutic relationship[2]. Despite evidence of harm and availability of safer de-escalation alternatives, restrictive practices remain persistent across Australian mental health services. The barrier is not knowledge but implementation: translating evidence-based alternatives into consistent, sustainable practice change[8].

Tasmania has emerged as a national leader in addressing this challenge. Its governance model balances clinical necessity with human rights[9] considerations by positioning people with lived experience as governance partners rather than care subjects. This recognition that sustainable reform requires cultural transformation, achievable only through meaningful consumer and carer involvement, has shaped a multi-tiered oversight system embedding lived experience perspectives at every level, from post-incident reviews to statewide policy development[10].

This approach warrants national attention. For consumers and families, reducing restrictive interventions is a fundamental human rights issue. For clinicians, it offers alignment between practice and therapeutic values, reducing moral distress. For policymakers, it provides a practical framework meeting both safety and human rights obligations. For the broader mental health system, it offers a replicable reform model.

Understanding Tasmania's model requires examination of the clinical and ethical context of restrictive interventions, the evidence regarding their use and impact, and detailed analysis of the governance framework, legal structures, and oversight mechanisms. Qualitative insights from clinicians and consumer representatives illuminate how the system functions in practice, revealing both strengths and areas for development. The case for national adoption rests on identifying the foundational implementation steps other jurisdictions must undertake.

This analysis is grounded in both scholarly literature and the practical realities of mental health service delivery. It acknowledges the complex challenges frontline services face in managing acute behavioural disturbances whilst maintaining an unwavering commitment to human rights and recovery-oriented care. Ultimately, it aims to contribute to a national conversation about creating mental health services that are simultaneously safe and genuinely therapeutic; services that respect the dignity and autonomy of every person requiring support during mental distress.

'It's not a restraint or a seclusion event; it's a human who has experienced a traumatic event that could potentially impact on their mental health engagement'

Restrictive Interventions in mental health care

Defining and evaluating Restrictive Interventions

Restrictive Interventions (RIs) constitute a significant and often controversial aspect of contemporary mental health care. While definitions may slightly differ across jurisdictions, broadly RIs are defined as any action that involves the deliberate restriction of a person's freedom of movement. Ideally, RIs are employed as a last resort measure when a person's behaviour is deemed to be so disruptive or dangerous that it poses a serious, imminent risk to their own safety or the safety of others, and all other therapeutic, non-restrictive de-escalation strategies have been exhausted or are judged inappropriate in the immediate context. The use of RIs has become increasingly regulated and subject to strict legal, ethical, and clinical review under frameworks that are designed to protect human rights and ensure the least restrictive form of care possible[11,12].

As defined by the Australian Institute of Health and Welfare[10], these interventions are categorised into four distinct, yet sometimes overlapping, types:

- **Physical** restraint is the direct application of bodily force by one or more staff members to safely contain an individual's movements. This might involve holding a person's limbs or body to prevent self-harm or harm to others, and it is considered a necessary, albeit invasive, action when other interventions have failed.
- **Mechanical** restraint refers to the use of physical devices to achieve a similar outcome, such as straps to secure a person to a bed or a posey vest to limit movement. The use of mechanical restraints is increasingly scrutinised due to their potentially dehumanising nature and is often reported as a rare occurrence in modern mental health practice.
- **Chemical** restraint presents a more complex category, defined as the administration of a psychotropic medication not for the primary purpose of treating a diagnosed mental health condition, but specifically to diminish a person's capacity for physical or verbal resistance. The distinction between chemical restraint and therapeutic pharmacological management can be clinically nuanced, making consistent reporting and ethical application challenging. The primary concern is that this form of medication is used not for healing but for compliance.
- Finally, **seclusion** is the deliberate confinement of an individual in a designated room or enclosed space to which they do not have free and voluntary access. This isolation is intended to remove triggers and allow for calm-down, but it can also be a profoundly frightening and re-traumatising experience for a person in crisis.

The use of these interventions is not arbitrary but are permitted within a stringent legal and ethical context. Nationally, their application is predicated on the principle of risk mitigation and is only legally and ethically justifiable when there is an immediate and significant threat. In Australia, the lawful application of RIs is tightly bound to processes of involuntary assessment and treatment under legislation such as state or territory-applicable Mental Health Acts. This legal framework ensures that restrictive measures are not used in lieu of proper psychiatric care but are a regulated part of a broader treatment strategy.

'When I use the term "care", I'm very clear that a restrictive intervention is not a treatment. It is not care. It is a restrictive intervention'

The overarching goal, enshrined in national policy, is a sustained reduction in the use of RIs, with the ultimate aspiration being their complete elimination from practice, as reflected in the national drive to minimise or eliminate the use of these practices from mental health services[10,13].

Understanding the continued use of Restrictive Interventions

Mental health care continues to use restrictive interventions despite ongoing ethical concerns. This reflects a fundamental conflict: the need to keep patients, bystanders, and staff safe in the moment versus the goal of respecting the dignity of the individual and supporting long-term recovery. The debate regarding the continued use of RIs continues, with arguments both for and against their use from both consumers and clinicians.

'I want to help create an environment where consumers feel safer and more respected – where restrictive interventions steadily decrease through consistent, rights-focused improvement'

From the consumer perspective, the argument for a reduction and eventual elimination of RIs is both powerful and almost universal. For individuals with lived experience of mental health care, seclusion and restraint are often described as profoundly harmful, re-traumatising events that can erode trust in the treatment system, exacerbate symptoms of psychosis or trauma, and leave lasting psychological scars[1,8,14]. The feelings of helplessness and powerlessness during an event can replicate past abusive relationships, undermining therapeutic efforts. While some consumers, in complex situations, may acknowledge that extreme measures like seclusion could have prevented a worse crisis, the overwhelming sentiment is that these practices are dehumanising and violate their personal autonomy and rights to dignity. Therefore, numerous consumer-led initiatives advocate for their complete eradication, promoting a recovery-oriented system built on relationships and choice[15].

The research literature provides a robust and consistent body of evidence that unequivocally supports a reduction in RI use. Systematic reviews and large-scale studies overwhelmingly document the physical risks, including asphyxiation, cardiac incidents, and musculoskeletal injuries, as well as psychological harms, such as increased suicidal ideation and symptom re-exacerbation[1,8,14]. Internationally, there is a pronounced lack of high-quality evidence to support the therapeutic efficacy of RIs. Research in Australia[16] has found a strong consensus across consumer, carer, and professional groups that seclusion and restraint have no therapeutic value and represent a failure of the care system[17]. The research thus argues that while RIs may be an inevitable response to an acute crisis in some cases, they are not treatment. The focus of evidence-based practice must therefore shift toward proven, proactive strategies for prevention, such as de-escalation training, improved ward environments, and early intervention services, to render RIs obsolete[1,15].

'If we reach a point where we're not researching it, then that's a point where we're happy with where things are. So, it should be something that is constantly looked at'

Clinicians, on the other hand, operate in the front lines of a high-pressure environment and often present a more complex, conflicted viewpoint. The primary argument for the continued, albeit highly regulated, use of RIs is the protection of life and reduction of harm[18]. A small subset of individuals experiencing a severe and agitated psychotic episode, acute mania, or profound self-destructive behaviour can present an acute, unpredictable danger. In these fleeting moments of crisis, clinicians state that RIs can be necessary; they may be the only tool available to prevent serious injury or death, for the individual, for other patients, or for staff. The argument is not for their desirability, but for their role as a safety-critical backstop[19]. However, the argument against their use, echoed by many clinicians themselves, centres on their detrimental impact on the therapeutic alliance.

'It's the therapeutic relationship that is going to assist the person not escalating to the crisis point for the need for restrictive interventions'

The use of force can shatter the trust painstakingly built with a patient, making future collaboration far more difficult. Research supports this, showing that RIs can damage staff-patient relationships and lead to increased staff burnout[14]. Clinicians in well-resourced, trauma-informed services often advocate for their reduction, seeing it as an indication of a higher quality, more sophisticated level of care[20].

Reducing Restrictive Interventions: "The goal of zero"

As articulated in national and international calls for reform, there is a vision of a mental health care system free from the use of seclusion and restraint. The fact of whether it is an attainable or unrealistic goal may be up for debate; however, it remains a necessary ambition. While the practical reality of acute psychiatric care means that providers must be prepared for a full spectrum of behaviours, this does not negate the moral and clinical imperative to strive for zero use of RIs. The mere existence of a pathway to use RIs should not be confused with its justification to be utilised as a matter of routine. The pursuit of zero is grounded in an unambiguous ethical foundation: that treatment for a medical condition should not involve the experience of trauma or the denial of autonomy[9]. It is a goal that challenges every facet of the mental health system, from workforce training to environmental design, to become better[11].

'Unless it's resourced properly, there will always be restrictive interventions. So, what matters to me is that I want there to be as few, and for as little period of time, as possible, and for their human rights and dignity to be absolute'

Until this ideal is fully realised, the paramount importance is that any continued use of RIs is subject to the most stringent governance, oversight, and review processes available. These processes are not mere bureaucratic requirements; they are the essential safeguards that transform a potentially punitive system into a restorative one. They ensure that every event is recognised as a serious incident, a system failure that requires deep reflection and learning. This level of accountability acts as a powerful check, ensuring that RIs are used only when absolutely necessary, for the shortest possible time, and with the most humane care possible. Until the ideal of "the goal of zero" is an end state that can be reached, it should forever remain a compass that guides a culture of ever-greater humanity, safety, and effectiveness in mental health care.

Restrictive Interventions: The Tasmanian context

Mental Health Care in Tasmania

The Tasmanian mental health system has established a clear, measured, and data-informed trajectory in its management of RIs, driven by a fundamental commitment to the principles of safety, dignity, and human rights. A comprehensive snapshot of the current state of RIs in Tasmania reveals a landscape of both challenge and significant progress.

According to the most recent Annual Report from the Chief Psychiatrist[21], in the 2024-25 reporting period Tasmania recorded a seclusion rate of 5.6 events per 1,000 occupied bed days. This represents a commendable decrease from the 7.8 events per 1,000 bed days recorded in the previous 2023-24 period[22]. More significantly, this rate now sits below the commonly accepted national benchmark of fewer than 6 seclusion events per 1,000 bed days, positioning Tasmania as one of the leading jurisdictions in the nation for seclusion practice.

Tasmania's mental health restraint rate for 2024-25 is not explicitly broken down by rate per 1,000 bed days in the 2024-25 Annual Report[21]. However, data from previous years up to and including 2023-24 indicate a continuing reduction of physical restraint in mental health care across the state; a rate of 8.5 per 1,000 bed days, a decrease from the previous year of 9.7. The use of chemical and mechanical restraints across all Tasmanian inpatient services is near zero[13]. These quantitative achievements are not merely statistical; they are the outward expression of a sustained, system-wide cultural shift towards less restrictive, trauma-informed care.

'Certain illnesses can be managed far better without restrictive interventions'

This momentum for change is further amplified by current and proposed reform efforts within the Tasmanian health system. A primary driver for reform is the recognition that frequent use of RIs is an indicator of systemic stress, often stemming from inadequate community support, a shortage of step-down services, and overcrowded acute care facilities. When alternatives are scarce, the acute care setting becomes the default response, increasing the pressure on frontline clinicians and, consequently, the risk of escalation. These stressors are further exacerbated by the constraints of the clinical environment, such as high bed turnover, high patient acuity, and stretched staffing levels, which can erode the time needed for the relational care that prevents crises in the first place.

'We compensate for infrastructure and staffing. Getting towards zero is probably impossible given the constraints we've got'

The realism of achieving a zero-RI future in current clinical practice is also a key consideration. While the ultimate goal of zero is paramount, clinicians within Tasmania acknowledge that an absolute zero in the immediate term is unlikely. The episodic and acute nature of certain mental illnesses, and the unpredictability of the effects of substance use on mental health, means that safety-critical situations will, on rare occasions, require immediate intervention to prevent serious harm. Therefore, the pragmatic focus is not on denying this reality, but on creating a system where RIs are an extreme, exceptional measure of last resort, used only when all pre-emptive and preventative strategies have been unsuccessful.

*'I have experience of what it's like to have restrictive practices used on me. I've also seen the impact that it has. There's a scale, least restrictive to most restrictive, and you need to look at it and go "is it really necessary to **that** extent?"'*

Tasmania's commitment to improvement

The foundation of Tasmania's entire approach to mental health care is its set of non-negotiable guiding principles, which are explicitly applied to the use of RIs.

- The first is **least restrictive care**, which mandates that any intervention must be the least intrusive method capable of providing the required level of safety. This principle is legally and ethically central to the entire framework[3].
- Second is **trauma-informed practice**, which recognises that many individuals experiencing a mental health crisis have a history of trauma. This principle requires clinicians to respond in ways that do not re-traumatise the individual, ensuring that the environment and the actions taken are perceived as safe and supportive rather than punitive or threatening[23].
- Third is **dignity**, which demands that even in the most constrained circumstances, a person's inherent worth, privacy, and choice are respected. This includes the right to be informed, to have access to personal items, and to be treated with courtesy[21,24].
- Finally, **safety-first** forms the dual-purpose imperative: to ensure the safety of both the person experiencing the crisis and the staff, families, and other patients around them.

These principles are not aspirational slogans; they are operationalised tenets that guide every decision, from staff training to the physical design of seclusion rooms[21,24].

To turn these principles into practice, Tasmania employs a suite of proactive, de-escalation, and therapeutic approaches. The Safewards[25] framework is a cornerstone of this strategy. An evidence-based model, Safewards identifies and mitigates "conflict triggers" on acute wards through ten practical interventions[26], such as creating mutual help among patients, managing discharges, and using positive words to communicate. By addressing the environmental and social factors that precipitate escalation, Safewards aims to reduce the number of instances that may have otherwise resulted in RI use.

'Any strategies that are going to be worked out with the consumer need to explore ways of prevention: "Was there something we did? Was there something we didn't do"?'

Complementing this is MAYBO[27] de-escalation training, which equips frontline staff with practical skills to manage challenging situations. This training emphasises non-confrontational communication, understanding non-verbal cues, and using personal space effectively to defuse tension, reserving physical intervention only for when all other strategies have been exhausted.

To further reduce reliance on RIs, services incorporate environmental improvements and sensory supports. These include dedicated calming or sensory rooms equipped with soft lighting and comfortable furniture, the use of weighted blankets for sensory regulation, and ensuring patients have access to natural light and outdoor spaces where possible. These non-pharmacological tools provide individuals with

alternatives to manage their distress, thereby preventing the need for more restrictive measures.

'Our C.A.R.E. values, compassion, accountability, respect, and excellence. That's what we're trying to be in mental health'

A final, critical element in the prevention and mitigation of crises is the therapeutic relationship. A strong, trusting rapport between a patient and their care team is often the most powerful de-escalation tool. It fosters open communication, allows for the early identification of warning signs, and increases a patient's willingness to accept support. However, the very structure of acute inpatient care, with its shorter admissions, high bed turnover, and limited step-down options, can make it difficult for these relationships to develop.

These systemic constraints underscore a key area for future investment and reform through more effective resourcing. This includes the incorporation of peer support workers, proven to bridge the patient-clinician gap, and be highly valuable in reducing the need for RIs[8,24].

Restrictive Intervention use in Tasmania: Scope, settings, and authority

The application of RIs in Tasmania is not ad hoc but is strictly bound by a clear jurisdictional and policy framework designed to ensure lawful, proportionate, and accountable use. The jurisdictional applicability is limited to consumers who are subject to the Tasmanian *Mental Health Act 2013* (MHA)[3]. The MHA serves as the primary governing legislation, defining the legal processes of involuntary assessment and treatment, and within which the use of seclusion and restraint is

The pathway to permitted use of Restrictive Interventions under the MHA

The occurrence of a Restrictive Intervention is not an isolated event; it is the culmination of a series of legal and clinical steps established under the MHA. This pathway ensures that the use of coercion is only applied within a framework of robust due process.

It begins with a **Detaining for Assessment**, through channels such as Emergency Departments or paramedicine, which allows qualified staff, such as a believe is suffering from a mental illness and whose safety, or the safety of others, is at risk if they are not detained. This initial detention is time-limited and serves as the prelude to formal assessment.

Within this timeframe, the individual is transported, often via emergency services, to one of the gazetted assessment centres. There, an **AMO** conducts an assessment. If the criteria are met, the AMO can make an **Assessment Order**, which allows for the person to be assessed in a more controlled environment for up to 24 hours. This order can be affirmed by a second AMO, extending it to a total of 72 hours.

If, after this 72-hour assessment period, the individual is still deemed to be acutely unwell and in need of involuntary treatment, the AMO can apply to the **Mental Health Tribunal** for an **Interim Treatment Order** or a full **Treatment Order**. This is the point at which longer-term involuntary treatment, and by extension, the continued lawful use of RIs if necessary, is authorised.

authorised. The Chief Psychiatrist's Standing Orders[24], issued as clinical directives, provide the operational specifics for how these interventions must be carried out, including documentation, duration limits, and the frequency of medical reviews.

RIs in inpatient care are lawful only at specific, gazetted sites; these designated facilities are the only sites where involuntary treatment and the use of RIs in inpatient settings can occur. The list of these centres is clearly defined and includes:

- the Royal Hobart Hospital Mental Health Inpatient Unit (2K West, 3K West, High Dependency Unit [HDU]);
- Launceston General Hospital – Northside (includes HDU);
- North-West Regional Hospital – Spencer Clinic (includes HDU);
- Wilfred Lopez Centre (Forensic Secure Unit, Lindisfarne);
- Millbrook Rise Centre, New Norfolk (Clyde, Tyenna Green, Tyenna Blue secure unit);
- the Roy Fagan Centre.

The delineation of these sites ensures that oversight and training are concentrated and consistent.

The use of these interventions requires a clear chain of authorisation. The final authority for the application of seclusion or restraint resides with an Approved Medical Officer (AMO), typically a doctor with specific accreditation under the MHA. The AMO must issue a formal authorisation, which is time-limited and subject to review occurring no later than a period of three hours, to reassess the necessity of the intervention. Nurses are critically involved in the implementation and monitoring of these interventions; however, they must be formally designated as Mental Health Officers (MHOs) or approved nurses under the MHA, which requires specific training and endorsement. This structured approach to authorisation ensures that responsibilities are clearly defined and that accountability is maintained at senior clinical levels[3,24].

It is imperative to stress that RIs may only occur during a lawful detention or treatment phase under the MHA and for the duration specified in the Chief Psychiatrist's Standing Orders[24]. Even when authorised, the humane care requirements are stringent. In the event that an individual is subject to seclusion or restraint, they must be observed by a nurse every 15 minutes, ensuring their immediate safety and comfort. They must be provided with regular access to food, fluids, and toileting facilities, and their care plan must be continuously reviewed. These mandated checks and provisions are not optional; they are the essential elements that ensure the intervention, however restrictive, is carried out with the utmost regard for the person's basic human rights and physical well-being.

Tasmania's Restrictive Intervention governance and review structure

Incident reporting, registers, and data

Oversight of restrictive interventions in Tasmania is built on a deliberately layered system of documentation and review that begins at the point of care and extends to statewide governance[21,24].

The first and most fundamental layer of oversight is a system of mandatory, real-time incident reporting. Every single use of an RI, regardless of its duration or perceived seriousness, is considered a reportable incident. This data is first captured in the state-wide Safety Reporting Learning System (SRLS), a digital platform used by all health services to report adverse events and serious incidents. An RI event is logged under the category of behavioural or aggressive incidents, with specific fields to designate the exact type of

intervention used (seclusion, physical restraint, etc.). This ensures that every event is formally recorded in the system for clinical, quality, and safety monitoring from the very first moment.

'It's important that it's reported. It's important that what worked, what didn't work, what should be working, is examined on a regular basis'

Simultaneously, each episode is entered into the official Seclusion and Restraint Registers maintained by the Office of the Chief Psychiatrist (OCP). These are not supplementary records but the primary, legally mandated registers for all such events in the state. The maintenance of these registers is a critical responsibility of the unit, carried out by a designated local Legal Office Coordinator (LOC). The LOC is also responsible for ensuring that all MHA documentation is complete and compliant. This dual role of the LOC is to manage both the legal compliance and the reporting of RIs, ensuring a strong link between the legal and quality assurance functions of care. Monthly aggregated data from these unit-level registers is submitted by the LOC directly to the OCP, creating a centralised, state-wide dataset.

This data collection is not an end in itself but a powerful tool for driving change. The aggregated data feeds directly into the decision-making processes of the unit-level Restrictive Intervention Review Panels. It is used to create performance reports that track local trends, identify recurring patterns, and evaluate the impact of action plans. The data is also used for statewide performance reporting, providing transparency and accountability to the public and policymakers.

Critically, this data is aligned with national Key Performance Indicators (KPIs) for seclusion and restraint. By monitoring their performance against these national benchmarks, Tasmanian services can objectively measure their progress toward RI reduction and be held accountable for sustained improvement over time. The OCP is working towards centralising the use of this data, beyond reporting, for active clinical governance, identifying outliers, conducting deeper reviews, and providing targeted support to services that require it. This would complement the similar work currently undertaken at the unit level.

Tier 1 - Post-event reviews: Huddles and Debriefs

To complement the formal, data-driven processes, Tasmania has implemented a timely and human-centred approach to post-event review through formal Staff Huddles and Consumer Debriefs. These are distinct from, yet supportive of, the larger, monthly review panels.

'For the staff involved, they do a huddle after the incident to check on everyone's welfare. But also to check if, procedurally, there is something that has been missed, or that they should have done'

The process begins with the Staff Huddle, which is conducted as soon as possible after the conclusion of an RI event, once the situation has been stabilised and staff have completed their required care and documentation duties. This fully documented huddle is a rapid, facilitated meeting involving the clinical team who were present; its primary focus is on staff safety, well-being, and operational learning. The team discusses what went well, what the challenges were, the effectiveness of the de-escalation and containment strategies used, and identifies any gaps in teamwork or communication. This immediate reflection helps to decompress and

debrief staff, reducing vicarious trauma and burnout, and consolidates learning while the event is still fresh in everyone's memory[1,14,20].

Equally important, and conceptually aligned with the trauma-informed and consumer-centric principles of the service, is the Consumer Debrief. This is a separate, planned conversation between a senior nurse and the patient, conducted when it is clinically appropriate and when the individual is deemed capable of engaging. The primary purpose of this debrief is not investigation but healing and empowerment. It provides a dedicated space for the consumer to share their experience of the event, to voice their perspective on what triggered it, how they felt, and what they think could have been done differently.

'It's a really important component because we can sit down and say to them "we need to talk about what you need and what we can do to help you. How can we make it better for you?"'

This dialogue is invaluable for co-designing individualised strategies to prevent future crises, such as identifying calming techniques, preferred staff members, or environmental triggers. It is a tangible act of restoring dignity and reinforces that the care team is listening. Family or carer input is also recognised, though a formal, dedicated family debrief is not mandated. This "unofficial" but encouraged practice allows for the inclusion of a valuable, often crucial, perspective on the individual's care[1,11].

Tier 2 - Monthly unit-level governance: Restrictive Intervention Review Panels

The cornerstone of Tasmania's review architecture, and what emphasises Tasmania as a leader in the mental health sector, is the monthly Restrictive Intervention Review Panel (RIRP). These are formal, de-identified review meetings held at the unit level, which provide the critical space for sustained, reflective analysis of all RI events. The purpose of the panel is to conduct a thorough, non-punitive review of every seclusion and restraint episode from the previous month to identify systemic strengths and weaknesses, ensure adherence to humane and ethical standards, track the completion of huddles, and develop specific, actionable improvements.

'The information that we're gathering in these meetings is actually disseminated and goes somewhere – there are outcomes and output"

These meetings are intended to be held monthly, and while clinical workloads can sometimes cause a meeting to be deferred, any missed incident reviews are set to be examined in the following meeting, ensuring no event goes undiscussed. The agenda for each meeting is structured and consistent, ensuring comprehensive coverage. Summaries are provided on each RI event, including details on the duration of the intervention, the clinical status of the person, the actions taken, and whether the humane care checks were maintained. A key focus is on any individuals that may have repeat episodes, recognising that chronic use of RIs on a single person is a critical area for intervention.

'What works well is the multidisciplinary approach that they have. So that doctors, nurses, carers, even ward aides and clerical staff are all a part of, and have input in to, that person's care'

The membership of these panels is deliberately designed to be multidisciplinary and, most notably, co-equal. The panel is typically chaired by a Senior Medical Representative or Senior Consultant Psychiatrist, ensuring a senior clinical and legal perspective. The co-chair is the Nurse Unit Manager (NUM), representing the nursing and operational leadership. In addition to other clinical staff, the panel includes dedicated and equal representation from a consumer representative (CR) and a family & friends representative (FFR). This inclusion is a nationally distinctive and profoundly significant feature of the Tasmanian model. Unlike advisory roles, these representatives are full, and equal, contributing members of the panel, ensuring that the lived experience contribution is not tokenistic or an add-on, but is embedded in core governance and review.

'I feel like the people with lived experience have the ability to understand what the consumer, or their families might be facing. They are able to balance the information and have input into improving the experience of both the consumer and the mental health professional'

The outputs of the RIRP are concrete and action-oriented. Based on their review, the panel generates local action items aimed at improving safety, care, and prevention. These may include action items including, but not limited to, targeted staff education on de-escalation, a review of environmental safety, a plan to improve the timely completion of consumer huddles, or a recommendation to purchase sensory items. The panels were established explicitly in response to national KPIs for reducing RIs, and their monthly cadence and the inclusion of CR and FFR representation at the operational level are unique and progressive in the Australian context.

'It's moved away from a clinician data-driven hitbox exercise to a rich environment where constant quality improvement and changing culture can occur'

Tier 3 - System-level governance: Seclusion and Restraint Oversight Committee

The final tier of the oversight structure is system-level governance, which ensures statewide consistency, alignment, and strategic direction. This is achieved through the Seclusion and Restraint Oversight Committee (SROC), a central committee chaired by the Deputy Chief Psychiatrist within the OCP. This high-level committee provides strategic oversight and ensures that the work of the individual RIRPs is synthesised into a coordinated state-wide effort.

'There is broad representation: safety and quality, consumers, family & friends, senior leaders, management. Together we examine services, trends, patterns for ways we can improve'

The membership of the SROC is designed to represent all key stakeholders in the system. It includes representatives from Safety and Quality, service executives, official visitors, a dedicated data analyst, and other senior clinical and leadership personnel. Additionally, like the RIRP, the SROC incorporates a CR and an FFR; this broad-based membership ensures that governance is informed by clinical, operational, quality, and lived experience perspectives.

'I can highlight how restrictive interventions might feel for the individual and bring attention to potential impacts that may not be visible in numerical datasets. It helps ensure discussions remain grounded in dignity, respect, and the broader human experience'

The reporting cadence creates a clear, upward flow of information and accountability. Each month, a Service Performance Report is produced, which aggregates all the Seclusion and Restraint Register data from across the state. This report is distributed to senior leadership for oversight of mental health services. The SROC uses this data and the quarterly reports from each RIRP to ensure ongoing alignment with national KPIs. It monitors statewide trends, evaluates the effectiveness of actions taken at the unit level, identifies persistent challenges, and can recommend policy changes, additional training, or strategic investments.

This top-down and bottom-up flow of data and feedback loops, from the frontline staff huddle to the central oversight committee, creates a feedback-rich environment where learning is continuous and improvement is systemic. It creates a mental health system that encourages transparency, promotes the reduction or RIs, and endorses the value of the lived experience voice.

'It strengthens trust with consumers, challenges assumptions, and encourages more thoughtful reflection on culture, communication, and alternatives to restrictive interventions'

Tasmania's Restrictive Intervention review structure: An analysis

Strengths: Where the system excels

The feedback from both clinicians and CRs reveals a strong consensus on a set of key strengths that are central to the success of Tasmania's approach.

The first and most celebrated strength is the multidisciplinary nature of the RIRPs with the inclusion of lived experience voices. Participants universally value the presence of consumers and families at the table as full and equal members. Both clinicians and CRs believe this composition fundamentally improves the quality and ethical grounding of the reviews.

'It helps consumers understand how seriously clinicians take restrictive interventions'

'It increases transparency, and ensures that restrictive interventions are considered not just procedurally, but humanely'

For clinicians, it challenges institutional assumptions and shifts the focus back to the human experience, ensuring language used in reports is respectful and person-centred. For CRs, it provides a direct channel to advocate for the rights and dignity of consumers, ensuring that their voices are not just heard but integrated into decision-making. A skilled panel chair is recognised as being crucial to maintaining a constructive and trauma-informed dialogue.

'It positively influences your thinking about language, and grounding you that this is an individual you are talking about'

'I can see the broader impact it has on everyone else as well, like families, nurses, doctors – all the staff, really'

Second, there is universal agreement on the strength of a reflective learning culture over mere compliance. Both groups appreciate that the panels do not exist as a bureaucratic "tick-box" exercise to verify that forms were completed. Instead, the focus is on a deep, reflective discussion of what went well, what could have been done differently, and how to prevent a similar event in the future. This focus on learning and prevention, rather than blame, fosters innovation and leads to tangible changes on the wards, such as adjusting staffing schedules or improving discharge protocols, which are seen to reduce the need for RIs over time.

'It supports our practice greatly. It supports us to stay on track with trauma-informed care, person-centred care, and strengths-based nursing principles'

'Our input is valued. Absolutely. Without a shadow of a doubt. Not just as an oversight, but from everything they are able to learn from us.'

A third major strength is the system's ability to engage in trend spotting to prevent incidents. By reviewing data monthly across multiple cases, the panels are able to identify patterns that might be missed at the individual patient level. These can include dangerous times of day, handover gaps between Emergency Departments (EDs) and inpatient units, or the lack of orientation for new admissions. Both clinicians and CRs see this macro-level analysis as a powerful tool for proactive system change, allowing services to target resources and implement fixes before individual crises occur.

'The aspect that's most effective is that we are just all getting together and reflecting'

'We tend to pick up on things they might miss, read between the lines. We look at the "why" - look at the things the staff may not see'

Challenges and priorities for improvement

While the system's strengths are notable, both clinicians and CRs identify several areas requiring focused attention. Meeting reliability and attendance consistency emerges as a primary challenge. Clinical pressures sometimes force panel cancellations or result in incomplete attendance by key staff members directly involved in incidents. This can delay learning and weaken the translation of insights into bedside practice. Services are responding by protecting time for panels, nominating senior champions to remove barriers, and strengthening administrative support to ensure agendas, concise case packs, and minutes are reliably produced.

'Ideally the meetings should occur every month. It's extremely hard – if there's a clinical crisis, it might get cancelled. We make sure we make up for it and cover every case. So, meetings get longer the more we miss'

Post-incident learning consistency represents another shared concern. While the value of immediate, structured conversations through huddles and debriefs is universally recognised, their completion remains inconsistent. Staff huddles occur more regularly than consumer debriefs, which can be delayed by clinical acuity, staffing pressures, and uncertainties about optimal timing. In response, a statewide, trauma-informed template for huddles and debriefs is being implemented to standardise content and quality. Completion and quality of huddles are increasingly used as panel performance indicators, helping embed the expectation that learning is not optional.

'The huddle for the consumer after every intervention is a critical aspect, and it doesn't always happen. I don't know if that's a procedure, timing, or resource issue'

Data quality and depth present a third challenge. Incident narratives often skew towards behaviour-only descriptions that omit crucial contextual information; the "why" behind escalation and the consumer's own account. This limits trauma-informed analysis and reduces statewide pattern detection capabilities. A minimum dataset is being introduced that rebalances documentation towards consumer-centred fields: antecedents, triggers, helpful and harmful responses, sensory supports, and effective staff mixes.

'The data currently only really looks at behavioural and procedural aspects – it doesn't reflect the person's experience. I guess the people reviewing this stuff need to be reminded there is a person in the centre of this'

The emergency department interface requires particular attention. Many restrictive interventions are "seeded" in emergency settings due to environmental intensity, role ambiguity during crises, and pressured documentation. Misaligned expectations, such as inconsistent messages about nicotine management or access to belongings, can precipitate conflict on arrival. To address this, emergency clinicians are being invited as regular participants in relevant panel reviews, and shared protocols are being developed for common flashpoints.

'ED consultants are coming now; that's very important because that's a space where there's lots of opportunity for improvement'

Environmental and infrastructure limitations also impact practice. Some high-dependency areas are not sufficiently calming, and seclusion rooms may not consistently meet national standards[28], including access to daylight, a visible clock, and anti-ligature design. A staged programme of environmental improvement is underway, focusing on both low-cost, high-impact changes and longer-term remediation projects.

Bridging differences: Aligning clinical and lived experience perspectives

While clinicians and CRs share the same ultimate goal of reducing restrictive practices, they naturally bring different emphases to their analysis. Clinicians tend to focus on processes, data, and systemic efficiency such as whether documentation was complete, whether timelines were met, or whether protocols were followed. CRs, conversely, emphasise human rights, dignity, and the practical, consumer-centred details that can make the difference between escalation and de-escalation.

Rather than seeing these as competing priorities, the Tasmanian system is developing practical mechanisms for bridging these differences. Reviews are currently underway to create integrated documentation that ensures that clinical forms capture both process requirements and consumer-centred information. Templates aim to include fields for antecedents, triggers, communication approaches, rights considerations, and witness impacts, alongside traditional clinical metrics.

Aligning SRLS incident reporting with panel review is a further step, using the same structured, consumer-centred fields in both processes. This will reduce administrative burden while raising informational value. Statewide oversight can then provide dashboards that report not only rates and durations of seclusion and restraint but also the qualitative themes that drive them, such as common antecedents, environmental triggers, points of friction at handover, and uptake of specific preventive strategies. This fusion of quantitative and qualitative signals will make the system more transparent, responsive, and learning-oriented.

Clinicians have raised concerns regarding the pathways to clinical care, and that strengthening the ED interface is central to alignment. Regular ED participation in panel reviews of incidents that originate in, or traverse, ED fosters shared ownership of problems and solutions. Shared protocols for recurrent flashpoints (e.g., nicotine management, property management, early limit-setting), consistent use of trauma-informed communications, and improved handover that includes the person's preferences and known triggers, enable receiving teams to position for success. As ED staff see their perspectives reflected in panel outputs, and mental health inpatient units receive coherent, preference-rich handovers, culture shifts from parallel lines to partnership aligning with CRs priorities on consumer-centred care.

Scaffolding for CR participation in review processes also matters. Standardised induction that includes site tours (especially high-care and seclusion areas), role-relevant policy access, a clear glossary, and predictable agenda management enables CRs and FFRs to contribute with precision. Timely pre-reading respects the depth of the lived-experience contribution. Clear support pathways, including debrief options after exposure to distressing content, promote psychological safety and sustainability in CR participation. These measures answer CRs' practical concerns while making clinical engagement with consumer input more efficient and fruitful.

Taken together, these alignment strategies deliver benefits at three levels. Systemically, integrated templates, aligned reporting, and reliable meeting mechanics create a streamlined pipeline from incident to improvement. The system becomes easier to run and easier to learn from, with a single dataset serving safety, clinical, and oversight needs. Transparency increases when consumer-centred content is consistently recorded, actions are tracked to closure, and statewide oversight can communicate not only statistics but also the themes and practice changes behind them. Most importantly, restrictive interventions reduce when learning is embedded into portable care plans, when ED-to-ward continuity is strengthened, when environments become more therapeutic, and when peer roles and trauma-informed skills are present at the point of care.

'There are a lot of learning opportunities here. We need to work toward a higher level of maturity around learnings and outcomes and not repeating the same thing over and over again. Like, how do we do better with sharing what we have learned?'

Tasmania's model: A chance for national reform:

Why this model works: Human rights and empirical outcomes

The superiority of Tasmania's model is not merely a matter of good policy; it is firmly grounded in international human rights law and a growing body of empirical evidence.

The human rights imperative

The United Nations' Convention on the Rights of Persons with Disabilities (UN-CRPD) interprets the right to liberty and security of person as a prohibition on the detention of persons with disabilities based on their impairment. It requires that any deprivation of liberty must be a last resort, strictly necessary, and subject to independent review[9,29]. Critically, General Comment No. 1 demands the full participation and inclusion of persons with disabilities in decision-making processes that affect them[30]. Tasmania's RIRPs operationalise this principle by ensuring that people with lived experience are not just passively consulted or informed. Instead, they are active, free participants with valued input. This model embodies the UN-CRPD's principle of "Nothing about us without us" in the most sensitive context: the review of a patient's personal, often traumatic, experience with restrictive practices. Through the incorporation of lived experience[31], Tasmania moves beyond tokenistic engagement to authentic inclusion, setting a standard for all Australian states and territories to meet.

'We're able to cut through and say: "hold on – I know you're dealing with this stuff every day, but that is not a satisfactory situation". Dignity, human rights – they're paramount'

Empirical and organisational benefits

The benefits of integrating lived experience into clinical governance are not just ethical; they are practical and measurable. Research[32] consistently shows that authentic co-design improves service quality, staff attitudes, and ultimately, patient safety. A crucial element of Tasmania's success is the monthly review cycle facilitated by the RIRPs. This enables a rapid feedback and continuous improvement system that is far more effective than annual reviews or sporadic audits. Monthly analysis allows services to learn from incidents promptly, identify emerging trends, and adapt their preventative strategies in near real-time, preventing cycles of recurring events.

'Our focus is on improving outcomes for patients. Not just outcomes but also their experience of care; how can we plan to do better next time? Lived experience involvement has been the enabler for that'

The integration of staff training, such as MAYBO[5], with the review process further strengthens this system. By having the RIRPs routinely assess the application of de-escalation techniques, a direct feedback loop is created. If a trend suggests an increase in incidents where de-escalation wasn't attempted, the panel has the ability to identify gaps where additional or improved training can be implemented.

This closes the gap between policy, practice, and professional development, fostering a culture of learning rather than blame. The Australian Institute of Health and Welfare's data[10,13], which shows a national trend toward reduced use of restrictive interventions, demonstrates that collective action can yield results; Tasmania's model provides a robust framework to accelerate and sustain this progress.

Australian jurisdictions: A comparative analysis

Tasmania's governance of restrictive interventions is legally tight, operationally consistent, and ethically grounded in lived experience; it serves as a practical blueprint for national reform. Its distinctiveness lies not only in the rigour of its reporting and oversight, but in the structural power it gives to lived experience at the operational review level. Embedding lived experience in this process is not peripheral: CRs and FFRs are full panel members, shaping analysis and actions with equal standing alongside clinicians. That design choice is transformative. It operationalises human rights principles within everyday clinical governance rather than relegating them to strategy documents.

All Australian states and territories have, through their policies and strategies, acknowledged the necessity of reducing or eliminating restrictive practices. All jurisdictions each demonstrate movement in the direction of reduction of RIs, yet each adopt their own approach to governance. With each of the state and territory models varying so significantly in structure, review frequency, and the depth of lived experience integration, there are different strengths and weakness in each approach.

New South Wales: Strategic intent, missing operational mandate

New South Wales has conducted significant reviews, such as the independent *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities*[33], which recommended a stronger focus on recovery and co-design with lived experience. The system mandates debriefing after incidents.

However, NSW lacks a standardised, recurring operational review panel structure across all mental health facilities that is equivalent to Tasmania's RIRPs. Lived experience is primarily engaged at a strategic or advisory level, such as through consumer consultation groups, which provide valuable input but do not necessarily have a formal role in the day-to-day analysis of incidents and the development of local solutions. The focus appears to be on broader service-level action plans and strategic directives rather than the monthly, data-driven, facility-specific continuous improvement cycle that is central to the Tasmanian model.

Victoria: Highly progressive law, operational gaps

Victoria leads the nation legislatively with the landmark *Mental Health and Wellbeing Act 2022* (Vic)[34], which embeds a "lived experience principle" into its core, stating people's lived experience of mental illness and psychological distress is important and should inform support, care and treatment.

Following a Royal Commission into their mental health system, Victoria has set the ambitious goal of eliminating restrictive interventions in designated mental health services by 2031. This strong legislative foundation is a significant advancement. However, an analysis of available guidelines and reports suggests that the translation of this principle into operational governance is inconsistent. While individual health services may have review processes, there is no statewide mandate for a formal operational panel structure analogous to the RIRPs in every facility.

The Mental Health and Wellbeing Commission's reports[35] indicate that lived experience is expanding, but advisory groups often operate separately from clinical incident review forums. This structural separation means that while lived experience informs high-level policy, its role in the tactical, immediate review of a specific seclusion event where it could have the most direct impact on change, remains barely advisory. Consequently,

the model falls short of the integrated, operational co-governance that Tasmania has realised.

Queensland: Individual focus and progressive policy, missing systematic governance

Queensland's governance is characterised by progressive policies and stringent authorisation requirements for mechanical restraint and seclusion, as outlined in the *Mental Health Act 2016* (Qld)[36]. A distinctive feature is the requirement for individual Reduction and Elimination Plans[37] for patients subject to frequent restrictive interventions. This highly personalised approach acknowledges the need for tailored care.

Nonetheless, Queensland does not have a standardised, mandated service-level review structure to oversee the use of restrictive practices across its facilities. This means the focus is heavily on individualised clinical planning rather than a systematic, facility-wide governance mechanism for collective learning and prevention. While Queensland is making commendable efforts, including the development of a Lived Experience Workforce Framework[38] to expand peer roles, these roles are not embedded as members with within a statewide network of operational incident review bodies. Without this structural mandate, the potential for systemic change at the unit level is fragmented.

Western Australia: Strong reporting, lacking review structures

Western Australia has an in-depth RI recording system[39] in which all instances of seclusion or restraint must be fully documented and reported to the Chief Psychiatrist within 48 hours[40]. However, Western Australia does not have any formal or standardised review process for RIs, with all review processes determined by each health service provider.

The *Mental Health Act 2014* (WA)[41] is currently undergoing review by the Mental Health Commission. Consumer organisations are advocating for concrete plans for the reduction and elimination of RIs, and call for more transparent reporting, review processes, with consumer and carer inclusion[42]. Western Australian Government has committed to reviewing RIs, however no timeline has been provided.

The Office of the Chief Psychiatrist also has a Lived Experience Consultation Group (LECG)[43] which provides advice "grounded in lived experiences and human rights principles". However, there is no indication of the LECG participating in any RI review processes.

With the current review of legislation, as well as recommendations from the Mental Health Commission and mental health consumers, Western Australia is primed for positive change. Tasmania's model is a clear advancement in creating full transparency, strong reporting structures, and the integration of consumer inclusion in oversight processes to effectively reduce and eliminate restrictive practices.

South Australia: Aftercare focus, requires formal operational review

South Australia's approach is typified by its "Trauma-Informed Post Incident Conversation Guide"[44], which focuses on supporting an individual's recovery after an incident of seclusion or restraint. This is a valuable and necessary service-level response, demonstrating a commitment to aftercare and trauma-informed recovery. However, it functions as a service and individual patient response rather than a governance and quality improvement mechanism for the entire service.

Crucially, there is no state-mandated requirement for a recurring operational review panel at the service level that systematically analyses data, identifies facility-wide trends and root causes, and

drives systemic change. While a Chief Psychiatrist Standard mandates that peer workers or other lived experience representatives be involved in reduction initiatives[45], they are not part of a formal review body with decision-making authority. This means the input from lived experience is advisory and project-based, not a core component of the governance structure that reviews every incident and has the power to recommend changes to practice.

Northern Territory: A reform in progress

The Northern Territory is similar to Australian states in that there are specific directives[46] from the Chief Psychiatrist on how, in which circumstance, and by whom RIs can be administered.

The directives focus on process and patient safety, through post-restraint or seclusion processes, and include a focus on staff and patient debriefing. However, there does not appear to be any systematic or formal RI event review processes.

In 2024, the Northern Territory developed the Mental Health Lived Experience Engagement Framework[47], recognising the importance of lived experience voices in the development, review and redesign of mental health services. With the Northern Territory currently reviewing the *Mental Health and Related Services Act 1998* (NT)[48], they are in an ideal position to incorporate the lived experience voice in governance and review processes and create real and sustainable change in mental health care.

Australian Capital Territory: A Human Rights focus, but lacking oversight

The Australian Capital Territory has repeatedly demonstrated its progressive nature; firstly, it was the first Australian jurisdiction to adopt a legislative charter of human rights through *Human Rights Act 2004* (ACT)[49].

More recently, the Australian Capital Territory developed the *Senior Practitioner Act 2018* (ACT)[50], which provides independent oversight of restrictive practices. However, crucially, it does not apply to individuals in mental health care who are subject to the *Mental Health Act 2015* (ACT)[51].

Whilst there is a focus on strong reporting, detailed documentation, and both staff and patient debriefing post-RI event, there remains no information regarding review processes. The progressive nature of the Australian Capital Territory stands to truly benefit from adopting a clear, proven, and replicable national model; a framework that embeds lived experience as a co-governing force.

'When talking about restrictive interventions, what we need to look at, everywhere in Australia, is how do we do it where the person still has dignity, still has their human rights. If these practices sometimes need to happen, how can we make sure they have all those things?'

The National adoption of Tasmania's model

All Australian jurisdictions appear aligned on the goal towards the reduction of restrictive interventions, however, they each approach that goal differently. Tasmania stands apart as the only jurisdiction with a codified, operational model that places lived experience at the very heart of clinical review. To accelerate the national goal of eliminating seclusion and restraint, all Australian mental health services must look to Tasmania not as just an innovator, but as a proven leader whose model is ready for adoption.

Multiple jurisdictions have strong legislative statements, national KPI alignment, and system-level oversight. Some have meaningful advisory forums for lived experience. However, Tasmanian practice stands apart in the incorporation of lived experience in RI governance and review. The presence of CRs and FFRs as equal members on both unit and system-level panels is nationally distinctive. It offers assurance that decisions about practice, environment, and training are shaped by the people most affected by restrictive practices.

'I feel really valued to be able to be a part of this. – there hasn't been a single person that hasn't welcomed me. They've all been so appreciative of my opinion, my point of view, my lived experience'

Tasmania's model has been designed specifically for the Tasmanian context, that may not allow for direct application in each jurisdiction. However, there are certain fundamental principles that can be applied in all contexts to actively reduce restrictive practices in all contexts. Therefore, as a foundation, the following steps are recommended:

1. Mandate operational lived experience inclusion by law or policy. States and territories should legislate (or policy-mandate) that every mental health inpatient service with authority to use seclusion and restraint must convene monthly RIRPs (or equivalent) that include both clinical and lived experience representation, with equal member status.
2. Embed trauma-informed post-incident engagement. Require staff huddles promptly after events and consumer debriefs when clinically appropriate; monitor completion, timeliness, and quality as panel KPIs. Provide for "unofficial" (consent-based) family/friend conversations to enrich prevention planning.
3. Tie learning to individual care plans. Mandate a portable "restrictive intervention preferences" section in the person's care plan, updated after events and visible in ED and ward records. Audit timeliness and use.
4. Standardise an integrated reporting and review pipeline. Require real-time incident capture into the state incident system (e.g., Tasmania's SRLS) with structured fields for antecedents, triggers, dignity/rights, preferences, and witness impact.
5. Entry into Chief Psychiatrist registers (or equivalents). Creation of such a register where none exist.
6. Monthly unit-level review panel (established in Recommendation 1.) covers all RI events with a repeat-event focus, huddle completion/quality, and documented action items with owners and deadlines.
7. Quarterly reporting by panels to a central Seclusion and Restraint Oversight Committee (or equivalent), which is chaired by the Chief Psychiatrist or delegate and includes lived experience, safety & quality, executive leadership, and with a data analytics capacity.
8. Public transparency with depth. Annually publish statewide report that not only show rates and durations, but the qualitative drivers and practice changes (e.g., antecedents, environmental fixes, huddle quality trends, care-plan update rates) while protecting privacy.

By adopting these steps, jurisdictions will not only align with human rights obligations but also accelerate practical, measurable reductions in restrictive practices.

Tasmania shows that the levers of change, such as data credibility, predictable governance rhythms, and the structured presence of lived experience at the point of operational decision, are within reach.

Conclusion

The use of restrictive interventions in mental health care embodies one of the field's deepest tensions: between the immediate, real imperative for safety and the enduring, ethical imperative for dignity, autonomy, and recovery. This analysis has defined the nature and permitted use of RIs, weighed the arguments for and against their continued use from the perspectives of consumers, clinicians and research, and affirmed the moral compass of a zero-RI goal. Tasmania's legal, operational, and cultural architecture for RI governance and review delivers real reductions in seclusion and restraint, whilst addressing the complexities of its use. Most importantly, the state demonstrates a nationally distinctive strength: the embedding of lived experience as an equal voice at the operational level of monthly panel review, with structured escalation to a statewide oversight committee.

Interviews with clinicians and consumer representatives confirm that Tasmania's system has moved beyond compliance to learning. The monthly cadence, the discipline of huddles and panels, and the strategic synthesis by the Seclusion and Restraint Oversight Committee all contribute to a coherent, multi-layered governance and review system. Strengths are clear: multidisciplinary co-governance, reflective learning, trend spotting, robust data flows, and workforce development. So too are the work-in-progress priorities: meeting reliability, action follow-through, huddle consistency and quality, ED integration, embedding learning into care plans, and environmental improvements. Where clinicians and CRs differ in emphasis, not aim, the system has the tools to bridge the gap: documentation design, integrated pipelines, portable care plans, ED partnerships, and CR induction and support.

Tasmania's approach is not theoretical - it is demonstrably reducing restrictive practice events, and it is making their use rarer, shorter, and more humane when they do occur. This is the standard Australia needs. To achieve it nationally, states and territories should adopt Tasmania's model of operational governance, standardise integrated reporting and review, strengthen trauma-informed post-incident processes, tie learning to care plans, and incorporate lived experience capability.

The future we must build is one in which safety is achieved through partnership, understanding, and therapeutic care, not control. Until we reach the "goal of zero", strict governance, lived experience leadership, and relentless learning are not optional; they are the ethical minimum.

'I do think it would be nice for other jurisdictions to be able to hear that this is what we're doing. That it's not impossible to discuss a restrictive intervention episode. So, I think it's important they do hear that: if they're not involving lived experience folks, they should be'

'It's empowering; I feel like we can pass on our knowledge and experience to people – really give that hope that they need. I guess we have been able to raise things that would be for the broader benefit of everybody'

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Recognition of Lived Experience

MHLET and the Alliance deeply value the insights and wisdom of individuals with lived experience of mental health challenges. We believe that those who have navigated these struggles are not only the experts of their own journeys, but also vital contributors to creating a more effective and compassionate mental health system.

We acknowledge that lived experience provides unique and essential perspectives that must be actively integrated into mental health policy, service design, and mental health and suicide prevention strategies.

People with lived experience offer invaluable insights into what works, what needs improvement, and what services are truly meaningful. Their voices must be central to the decision-making processes that shape mental health care.

MHLET and the Alliance are committed to fostering an inclusive mental health system where lived experience is not only recognised but empowered. By valuing the voices of those with lived experience, we can create services that are truly person-centred, accessible, and effective for all.

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experience
knowledge
change
MENTAL HEALTH
LIVED EXPERIENCE
TASMANIA

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