POSITION STATEMENT

Eliminating Coercive Practices in Mental Health Services

VMIAC

ACKNOWLEDGEMENT OF COUNTRY

VMIAC recognises Aboriginal and Torres Strait Islander peoples as the First Peoples of this continent and the Islands of the Torres Strait.

In doing so, we acknowledge out shared history, recognise the right to self-determination and the importance of connection and access to Country.

VMIAC works across Victoria and acknowledges the Traditional Custodians of the lands and waters on which we are privileged to work and live.

We acknowledge and respect distinct Aboriginal and Torres Strait Islander cultural differences, beliefs, values, and languages.

We acknowledge that this land was never ceded and pay our respects to Elders past and present.

Position Statement: Eliminating Coercive Practices in Mental Health Services

1. Purpose

1.1. This statement establishes VMIAC's position on coercive practices[*] in Victoria's mental health system[†] and our expectations of government, services, and other statutory bodies in progressing reform towards their elimination.

1.2. It reaffirms VMIAC's unequivocal commitment to the total elimination of seclusion, restraint, and coercion in all mental health services.

1.3. In the interim, while coercive practices remain legally sanctioned and widely used, we demand urgent reforms to ensure:

- Transparent and comprehensive public reporting of all coercive practices;
- Meaningful and enforceable consequences for violations of the law and breaches of consumers' human rights;
- The immediate development and implementation of a coordinated, time-bound strategy with clear accountability for the total elimination of coercive practices; and
- Authentic consumer leadership embedded at all levels of system governance and decision-making.

2. Background

2.1. Coercive practices have long been embedded in Victoria's mental health system, routinely framed as 'necessary' or therapeutic despite overwhelming evidence of the harm they cause.[1,2] These practices have significant consequences; not only for consumers, who experience them as distressing and profoundly traumatising, but also for staff, who may suffer moral injury, psychological distress, and damage to therapeutic relationships as a result of engaging in or witnessing these practices.[3]

2.2. Evidence shows that coercive practices are frequently used excessively and unnecessarily, particularly in under-resourced settings where safe staffing levels and viable alternatives are lacking.[4] Although often viewed by practitioners as necessary for

[*] Commonly referred to as restrictive practices or restrictive interventions. VMIAC uses the term *coercive practices* to emphasise the inherent power imbalance and absence of genuine consent that underpin these interventions. This framing also acknowledges that harm extends beyond physical control to include emotional and psychological control.

[†] This document only addresses coercive practices authorised under the *Mental Health and Wellbeing Act 2022*.

maintaining safety, there is little evidence that these practices improve outcomes. On the contrary, research demonstrates that reducing coercive practices is associated with lower rates of violence and improved safety for both consumers and staff.[5,6] Clinical decision-making should be guided by evidence-based practice, which requires that interventions provide demonstrable benefit to the individual. However, reviews consistently highlight a lack of robust, high-quality evidence supporting the efficacy, efficiency, or therapeutic value of coercive measures.[7,8]

2.3. Efforts to eliminate coercive practices must also address the physical environments in which services operate and whether these support safe, dignified, and non-coercive care. Emerging evidence suggests that privacy, adequate personal space, quiet areas, and access to gardens and natural light can support reductions in seclusion and restraint.[9] Buildings vary in age and suitability, and improvements may require substantial capital investment.

2.4. Prior to the Royal Commission into Victoria's Mental Health System (the Royal Commission), Victoria recorded some of the highest rates of coercive practices in Australia, particularly the use of seclusion.[10] These figures were a key catalyst for the establishment of the Royal Commission, which recognised these practices as dehumanising and recommended their elimination.[11]

2.5. The *Mental Health and Wellbeing Act 2022* (the Act) includes a legislated objective to reduce and ultimately eliminate restrictive practices.[12] However, progress on this has been slow and inconsistent, with services continuing to use high rates of coercive practices in the absence of meaningful accountability. Critically, the Act neither defines nor regulates psychological restraint, one of the most pervasive and harmful forms of coercion, rendering it effectively invisible within the legal framework.

3. Defining coercive practices

3.1 Coercive practices are actions or interventions that override an individual's autonomy and are used to compel, control, or intimidate. These practices are not grounded in consent but in the exercise of power. They include:

3.1.1 Seclusion: the sole confinement of a person to a room or other enclosed space from which they are unable to freely leave.[13]

- This includes what is sometimes referred to as 'open seclusion', where a door may remain open, but any attempt to leave is met with intervention or redirection. Although not technically locked in, this effectively denies the person freedom of movement.
- Related practices described as 'confinement' restrict consumers to an area they cannot leave, even when others are present. These arrangements may fall outside the legal definition of seclusion but still restrict freedom of movement.

Where staff also withdraw to offices or behind secure glass, consumers may be left without readily accessible support and experience this as forced isolation or abandonment.

- The concern is not staff withdrawal alone, but whether those unable to leave or move somewhere safe can access help when needed. Restrictions on movement limit opportunities to leave unsafe situations or seek assistance elsewhere. If staff are also unavailable or slow to respond, distress or harm may go unnoticed and assistance may be delayed. Services that restrict freedom of movement retain responsibility for ensuring access to safety and timely assistance. Staff withdrawal must not compromise their ability to prevent and respond to distress, sexual violence, or other harm.

3.1.2 Physical restraint: the use by a person of their body to prevent or restrict another person's movement.[14]

3.1.3. Mechanical restraint: the use of a device, such as belts, straps, or cuffs, to prevent or restrict movement.[15‡]

3.1.4. Chemical restraint: the administration of medication to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement.[16]

3.1.5. Psychological restraint: a form of coercive control involving any communication or intervention intended to limit a person's behaviour or choices, often without their explicit awareness or consent.

- Often subtle and difficult to detect, these tactics include intimidation, implicit or explicit threats, restriction of access to information or support, conditional offers of assistance, and emotional pressure that undermines genuine autonomy.[17]
- This form of restraint closely aligns with the concept of *informal coercion*, a widely studied phenomenon in psychiatric settings. Informal coercion involves the use of interpersonal leverage, persuasion, inducements, or threats of negative consequences framed as therapeutic guidance or encouragement. Although not formal or legally sanctioned compulsion, these methods nonetheless restrict free decision-making and autonomy.[18,19,20]
- Psychological restraint is rarely formally acknowledged but can cause harm equivalent to physical or chemical restraint. It erodes trust between consumers and providers, retraumatises individuals, and perpetuates power imbalances. Moreover, it often reflects an institutional culture that privileges risk management and compliance over genuine collaboration, consent, and respect for the human rights and dignity of consumers.[21,22,23]

‡ Physical restraint and mechanical restraint are collectively referred to as bodily restraint.

- The exclusion of psychological restraint from current definitions of restrictive practices is a glaring omission. Its effects are no less harmful than physical interventions, and many consumers describe psychological coercion as the most pervasive form of harm they have experienced in the system.

4. Human rights and legislative context

4.1. The use of coercive practices in Victoria's mental health system violates multiple international human rights treaties that Australia has ratified, including:

4.1.1. The Convention on the Rights of Persons with Disabilities (CRPD), in particular:

- Article 12: Equal recognition before the law.
- Article 14: Liberty and security of person.
- Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment.
- Article 16: Freedom from exploitation, violence and abuse.
- Article 17: Protection of personal integrity.[24]

4.1.2. The Optional Protocol to the Convention Against Torture (OPCAT), which requires the prevention of torture and ill-treatment in all places of detention, including mental health facilities.[25]

4.1.3. The International Covenant on Civil and Political Rights (ICCPR), which protects the rights to liberty, security of person, and freedom from arbitrary detention and ill-treatment.[26]

4.1.4. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which affirms the rights of Indigenous peoples to self-determination, cultural integrity, and free, prior and informed consent.[27] The disproportionate use of seclusion and other coercive practices against Aboriginal and Torres Strait Islander peoples is inconsistent with these principles and reflects the ongoing impacts of colonisation and systemic racism within mental health systems.[28]

4.2. Coercive practices also breach key domestic legal protections, including:

- The *Disability Discrimination Act 1992 (Cth)*.[29]
- The *Charter of Human Rights and Responsibilities Act 2006 (Vic)*, particularly the rights to liberty and security of person (s21), humane treatment when deprived of liberty (s22), and protection from torture and cruel, inhuman or degrading treatment (s10).[30]

4.3. Despite these legal obligations, Victoria's *Mental Health and Wellbeing Act 2022* not only permits but actively authorises the use of seclusion, restraint, forced treatment, and involuntary detention. In doing so, it entrenches violations of fundamental human rights in state law.

5. VMIAC's Position

5.1. VMIAC condemns all forms of coercive practice as state-sanctioned violence. These practices are neither therapeutic nor evidence based. They violate consumers' human rights and cause lasting physical and psychological harm.

5.2. VMIAC rejects the use of seclusion, restraint, and forced treatment in any form. Their use constitutes a breach of our fundamental rights to liberty, bodily autonomy, personal integrity, and freedom from cruel, inhuman, and degrading treatment.

5.3. While the elimination of seclusion and restraint by 2031 is a legislated target, current trends suggest the Victorian Government may seek to delay or weaken this commitment. There is a real risk that it will be met only symbolically, while coercive practices continue under different names or in less visible ways.

5.4. We are deeply concerned about the following:

- There is still no comprehensive, system-wide plan to achieve the 2031 target.
- Psychological restraint – including threats, intimidation, withholding of privileges, and manipulative clinical interactions – remains unnamed, unmeasured, and unregulated in law or policy.
- Mental health services face no real accountability for ongoing breaches of legal and human rights.
- Consumers with lived experience of coercive practices remain excluded from leading the design, delivery, and monitoring of reform.

5.5. A system that relies on coercion cannot be called rights based. Elimination must mean total elimination; it cannot be reduced to euphemism, substitution, or silence. Any attempt to rebrand coercion as 'therapeutic intervention,' 'last resort,' or 'least restrictive' care is simply a continuation of harm under a different name.

5.6. *The elimination of coercive practices requires a whole-of-system transformation.* Coercion is not only the result of individual clinical decisions or inadequate policies. It is embedded within the structures, cultures, funding models, training approaches, risk frameworks, and governance systems of mental health care. Fragmented reforms will fail. Real change must be systemic, integrated, and sustained, with lived experience leadership central to this process. Government must resource this transformation, including adequate staffing, workforce development, voluntary alternatives to coercive care, and improvements to the physical environment.

5.7. This includes dedicated capital funding to upgrade or replace facilities that cannot adequately support non-coercive care. Investment must address the limitations of older and unsuitable buildings and prioritise environments that uphold privacy, dignity, and choice. Biophilic design, including natural light, gardens, and accessible outdoor spaces, should form part of this approach. Inadequate infrastructure must not be accepted as a justification for continued coercion.

6. Recommendations

6.1. Recognise informal coercion as a form of restraint

Amend legislation, policy, and service standards to explicitly define informal coercion, including psychological restraint, as a form of restrictive practice. Ensure it is subject to the same elimination targets, oversight mechanisms, and reporting obligations.

6.2. Publish a statewide elimination strategy

Develop and release a comprehensive public strategy for the elimination of all forms of coercive practices by 2031. This plan must take a whole-of-system approach, integrating reforms across legislation, service delivery, funding, workforce, regulation, and governance. It must include clear timelines, measurable targets, assigned responsibilities, and dedicated funding.

6.3. Mandate and fund environments that support non-coercive care

Introduce mandatory design standards for new and existing mental health facilities that uphold privacy, dignity, and autonomy and incorporate biophilic design. Provide dedicated capital funding and enforceable timeframes to bring existing facilities into compliance, prioritising those with the greatest need for improvement.

6.4. Mandate transparent and comprehensive reporting

Require the Mental Health and Wellbeing Commission to collect, analyse, and publish disaggregated data on all forms of restraint and coercion, including chemical and psychological. Reporting must, at a minimum, be disaggregated by service provider, location, gender, age, cultural identity, and First Nations status.

6.5. Hold services accountable with meaningful consequences for non-compliance

Introduce enforceable legal and regulatory consequences for services and individual staff that continue to use coercive practices or violate consumers' rights. Establish independent mechanisms for the systemic investigation of failures, beyond incident-level review.

6.6. Embed lived experience at every level

Ensure lived experience leadership is embedded across all stages of reform, from defining coercion to designing rights-based alternatives and evaluating outcomes. Consumer leadership must be resourced and empowered to shape decisions at every level of the system.

6.7. Acknowledge and redress harm

Publicly acknowledge the profound harm caused by coercive practices. Establish accessible pathways for individual redress, including formal apologies, restorative justice processes, peer-led support, and, where appropriate, financial compensation.

6.8. Extend the goal of elimination beyond mental health services

Advocate for the elimination of coercive practices across all systems where people are impacted, including aged care, disability services, educational facilities, police and emergency services, and forensic settings.

[1] Chieze, M., Hurst, S., Kaiser, S. & Sentissi, O. (2019) 'Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review', *Frontiers in Psychiatry*, 10(491). https://doi.org/10.3389/fpsyt.2019.00491

[2] Butterworth, H., Wood, L. & Rowe, S. (2022) 'Patients' and staff members' experiences of restrictive practices in acute mental health in-patient settings: systematic review and thematic synthesis', *BJPsych open*, 8(6): e178. https://doi.org/10.1192/bjo.2022.574

[3] Bigwood, S. & Crowe, M. (2008) '"It's part of the job, but it spoils the job": A phenomenological study of physical restraint', *International Journal of Mental Health Nursing*, 17: 215-222. https://doi.org/10.1111/j.1447-0349.2008.00526.x

[4] McKeown, M., Thomson, G., Scholes, A., et al. (2019) '"Catching your tail and firefighting": The impact of staffing levels on restraint minimization efforts', *J Psychiatr Ment Health Nurs*, 26: 131–141. https://doi.org/10.1111/jpm.12532

[5] Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O.-P., Kautiainen, H. & Tiihonen, J. (2013) 'Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men with Schizophrenia', *Psychiatric Services*, 64(9): 850–855. https://doi.org/10.1176/appi.ps.201200393

[6] Havilla, S., Alanazi, F. K., Boon, B., Patton, D., Ho, Y.-C. & Molloy, L. (2024) 'Exploring the impact of a multilevel intervention focused on reducing the practices of seclusion and restraint in acute mental health units in an Australian mental health service', *International Journal of Mental Health Nursing*, 33: 442-451. https://doi.org/10.1111/inm.13255

[7] Gupta, M. (2009) 'Ethics and evidence in psychiatric practice', *Perspectives in biology and medicine*, 52(2): 276–288. https://doi.org/10.1353/pbm.0.0081

[8] Sailas, E., & Wahlbeck, K. (2005). 'Restraint and seclusion in psychiatric inpatient wards,' *Current opinion in psychiatry*, 18(5): 555–559. https://doi.org/10.1097/01.yco.0000179497.46182.6f

[9] Oostermeijer, S., Brasier, C., Harvey, C., et al. (2021) 'Design features that reduce the use of seclusion and restraint in mental health facilities: a rapid systematic review', *BMJ Open*, 11: e046647. https://doi.org/10.1136/bmjopen-2020-046647

[10] Emden, C. (2024) 'Why are the rates of restrictive practices in Victoria's mental health services so high?', *Pursuit*, University of Melbourne. https://pursuit.unimelb.edu.au/articles/why-are-the-rates-of-restrictive-practices-in-victoria-s-mental-health-services-so-high

[11] State of Victoria (2021) *Final Report: Summary and Recommendations*, Royal Commission into Victoria's Mental Health System, Victorian Government Printer: Melbourne. https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report

[12] *Mental Health and Wellbeing Act 2022 (Vic)*, Part 3.7 – Restrictive interventions. https://www.legislation.vic.gov.au/as-made/acts/mental-health-and-wellbeing-act-2022

[13] Department of Health (2025) *Restrictive interventions - Seclusion*, Victorian Government. https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions#seclusion

[14] Department of Health (2025) *Restrictive interventions – Bodily restraint*, Victorian Government https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions#bodily-restraint

[15] Department of Health (2025) *Restrictive interventions – Bodily restraint*, Victorian Government. https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions#bodily-restraint

[16] Department of Health (2025) *Restrictive interventions – Chemical restraint*, Victorian Government. https://www.health.vic.gov.au/mental-health-and-wellbeing-act-handbook/treatments-and-interventions/restrictive-interventions#chemical-restraint

[17] Restraint Reduction Network (2023) *Psychological restraint: A guide for staff*. https://restraintreductionnetwork.org/wp-content/uploads/2023/07/RRN-Psychological-Restraint-Guide-for-Staff.pdf

[18] Faissner, M., Braun, E. & Hempeler, C. (2025) 'Epistemic oppression and the concept of coercion in psychiatry', *Synthese*, 205(24). https://doi.org/10.1007/s11229-024-04853-z

[19] Szmukler, G. (2024) '"Treatment Pressures" and "Informal Coercion": "Threats" in Mental Healthcare', *The American Journal of Bioethics*, 24(12): 89-91. https://doi.org/10.1080/15265161.2024.2416148

[20] Pelto-Piri, V., Kjellin, L., Hylén, U. et al. (2019) 'Different forms of informal coercion in psychiatry: a qualitative study', *BMC Res Notes* 12(787). https://doi.org/10.1186/s13104-019-4823-x

[21] Restraint Reduction Network (2023) *Psychological restraint: A guide for staff*. https://restraintreductionnetwork.org/wp-content/uploads/2023/07/RRN-Psychological-Restraint-Guide-for-Staff.pdf

[22] Aragonés-Calleja, M. & Sánchez-Martínez, V. (2024) 'Evidence synthesis on coercion in mental health: An umbrella review', *International Journal of Mental Health Nursing*, 33: 259-280. https://doi.org/10.1111/inm.13248

[23] Nyttingnes, O., Ruud, T. & Rugkåsa, J. (2016) '"It's unbelievably humiliating" – Patients' expressions of negative effects of coercion in mental health care', *International Journal of Law and Psychiatry*, Volume 49, Part A: 147-153. https://doi.org/10.1016/j.ijlp.2016.08.009

[24] United Nations (2006) *Convention on the Rights of Persons with Disabilities*, Treaty Series, 2515, 3. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

[25] United Nations (2002) *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*, A/RES/57/199. https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel

[26] United Nations (1966) *International Covenant on Civil and Political Rights*, Treaty Series, vol. 999, p. 171, 16 December 1966. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

[27] United Nations General Assembly (2007) *Declaration on the Rights of Indigenous Peoples*, 2 October 2007, Resolution 61/295. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[28] Office of the Chief Psychiatrist (2025) *Seclusion and restraint report 2020–24*, Victorian Government Department of Health: 19-20. https://www.health.vic.gov.au/sites/default/files/2025-11/office-of-the-chief-psychiatrist-seclusion-and-restraint-report-2020-24.pdf

[29] *Disability Discrimination Act 1992 (Cth)*. https://www.legislation.gov.au/Series/C2004A04426

[30] *Charter of Human Rights and Responsibilities Act 2006 (Vic)*. https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006

Phone: (03) 9380 3900
Email: reception@vmiac.org.au
Office: Level 3, 80 Dorcas Street, Southbank, VIC, 3006

vmiac.org.au