WITNESS STATEMENT OF PROFESSOR LISA BROPHY

I, Lisa Brophy, Professor and Discipline Lead, La Trobe University, 1 Kingsbury Drive, Bundoora, Victoria, say as follows:

Professional background

1 My name is Professor Lisa Brophy. I am the Discipline Lead in Social Work and Social Policy, Department of Occupational Therapy, Social Work and Social Policy at La Trobe University.

2 I am also an honorary principal research fellow in the Centre for Mental Health in the Melbourne School of Population and Global Health at the University of Melbourne, where I previously led the Recovery and Social Justice Unit.

3 I was recruited to the position of Director of Research at Mind Australia (Mind) in January 2011 in a position that was conducted in partnership with the Centre for Mental Health at the University of Melbourne. I was employed full time by the University in an innovative in-reach and capacity building position until I began to transition to my new position at La Trobe in 2018. My research focus has been on people who have lived experience of mental illness and psychosocial disability and their recovery, social inclusion and human rights. These research interests have continued in my new position that also requires leadership and service to La Trobe University and involvement in teaching Social Work students from undergraduate degrees to PhDs.

4 I have a Bachelor of Behavioural Science (1983) and a Bachelor of Social Work (1985). I have a career long commitment to the mental health field of practice dating back to 1985. I graduated with a Master's in Policy and Law from La Trobe University in 1995 and have a PhD from the University of Melbourne in 2009. My PhD focused on good practice with people on Community Treatment Orders (**CTOs**) and I have been involved in local and international collaborations regarding mental health law and its implications for policy, law reform and direct practice.

5 The findings from my PhD led to three publications in three different journals and two book chapters. My first publication regarding CTOs was in 2003[1] and my most recent

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[1] Brophy, L. & McDermott, F. (2003) What's driving involuntary treatment in the community? The social, policy, legal and ethical context. *Australasian Psychiatry*, Vol 11, S83- S89.

publication was in 2019[2], representing a 16-year history of publishing research activity related to CTOs.

6 I was a member of the expert advisory group that reviewed the Mental Health Act 1986 (Vic). I am a current sessional community member of the Victorian Mental Health Tribunal (the Tribunal) and I was reappointed in April 2018.

7 Attached to this statement and marked 'LB-1' is a copy of my Curriculum Vitae.

8 I am giving evidence in my personal capacity.

Compulsory treatment – definitions

9 I define compulsory treatment as an involuntary or compulsory admission to a hospital under an order made pursuant to the *Mental Health Act 2014* (Vic) (the **Act**) or a CTO under the Act.

10 As indicated, my research predominantly focusses on CTOs so throughout this statement, my major focus will be on the benefits and problems attached to CTOs. I have also undertaken research in relation to supported decision making, working towards the reduction and potential elimination of seclusion and restraint, and the locking of doors of inpatient units. I intend to also draw on this area of expertise. However, I do not define compulsory treatment to necessarily include restrictive interventions like restraint and seclusion. This is because restraint and seclusion are not a form of treatment per se and they tend to occur in circumstances where someone is already experiencing a compulsory order.

QUESTIONS FOR PANEL MEMBERS

Question 1: How and why does the approach to compulsory treatment in mental healthcare, differ to other areas of healthcare where greater agency is provided to individuals?

11 The fundamental difference for compulsory treatment to other areas of healthcare is that it can be imposed on people irrespective of whether they agree with the treatment being offered. Compulsory treatment removes a persons' ability to make their own decisions about their treatment and care pursuant to criteria in the Act. To exemplify this point, I use the example of a lung cancer patient who continues to smoke cigarettes contrary to medical advice. In these circumstances, as a society, we do not remove this patient's agency or decision-making ability in respect of their independent health and impose health treatment on them. However, this is not the case for mental illness. The Act

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[2] Brophy, L., Kokanovic, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community Treatment Orders and Supported Decision-Making. *Frontiers in Psychiatry*, 10, 1-12

enables substitute decision makers who, even though they are required to take into account the persons' views and preferences, are able to order compulsory treatment if the legal criteria for compulsory treatment are met.

12 Another key difference between compulsory treatment and other areas of healthcare, is the way that compulsory treatment is experienced by people in the mental health treatment context. Compulsory treatment can be experienced as punitive and coercive rather than as being supportive, caring and engaging a person with the mental illness and their specific needs. From the time that someone is placed on a compulsory treatment order, particularly if its early within their treatment, that experience of compulsory treatment will often shape the way they see mental health services and a negative experience of compulsory treatment can impede future engagement with services and treatment[3].

13 Additionally, using the existence of a mental illness as a criterion to determine when to provide compulsory treatment can be considered to be fundamentally discriminatory to those that have a mental illness[4].

Question 2: From your perspective, in what ways, if any, does compulsory treatment provide benefit to:

a. people living with mental illness, including children and young people?

b. family and carers?

c. the community?

d. diverting demand for more acute mental health services, such as admission to an acute mental health inpatient unit?

14 I would like to begin by first saying that the evidence for compulsory community treatment is highly contested. Randomised controlled trials have tended to focus on readmission to hospital and other outcomes and have not established evidence for the use of CTOs. However, other studies, such as case-control studies that have followed people over time have found inconsistent and conflicting results. There is often speculation that the positive results are due to the increased contact with services that come with a CTO. My colleagues and I have summarised this evidence in a recent book chapter[5]. This also

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[3] McMillan, J., Lawn, S., & Delany-Crowe, T. (2019). Trust and community treatment orders. *Frontiers in psychiatry*, *10*, 349.

[4] Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the UN Convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, *37*(3), 245–252.

[5] Brophy, L., Ryan, C. J., & Weller, P. (2018). Community treatment orders: the evidence and the ethical implications. In *Critical perspectives on coercive interventions* (pp. 42-55). Routledge.

includes a summary of qualitative evidence that, while it is mixed, suggests that many people are distressed and harmed by their experience on CTOs. Similarly, I have also found a persistent theme in qualitative research that compulsory community treatment may benefit some people living with mental illness, because it is one way to guarantee delivery of mental health treatment and services without a wait time for services to become available. There appears to be a sense that a CTO establishes an agreement between a person and a mental health service that they will receive follow up. For some consumers, I also consider compulsory treatment can be beneficial if they – and their treating team - feel like they have a guaranteed pathway into hospital admission if their mental health declines. However, one of the concerns about CTOs being a 'gateway' for guaranteed service delivery is the length of time that a person remains on a compulsory order, first in the inpatient unit and then in the community. This does not take into account the potential harms, such as loss of self-efficacy and stigma, that are being inflicted on the person as a result of being a compulsory patient. If a CTO is advocated for by clinicians before the Tribunal, as a mean of preventing the loss of service-delivery to a client who may no longer be on a compulsory treatment order, then these service considerations may be overtaking good practice and compliance with the underlying principles of the Act. I have described this as a long standing unintended consequence of CTOs, one that has potentially been compounded by increasingly strained resources[6]. I also observe that staff appear to be becoming more and more deskilled in relation to how continuity of care might be achieved without a compulsory order, even when the person is reluctant to engage or afraid of mental health services.

15 Within research, there is often a small group of people who either at the time, or on reflection, appreciate the structure of CTOs and see positives in the burden of their own decision-making being taken away from them. Other people on CTOs also view these orders as an important mechanism to enable them to be discharged from inpatient hospital environments[7]. In my own PhD research, I have observed that women, in particular, described benefiting from a CTO because they were able to get discharged from hospital, receive treatment in their community and attend to their family or childcare responsibilities. However, I have questioned whether this has become a net widening effect associated with CTOs that has seen them used with a broader group of people than initially intended. They are no longer reserved for supporting only people with the most complex needs to receive less compulsory care and avoid persistent readmission to hospital or being "revolving door" patients, rather we now see them being used in other situations such as in the context of people having their first episode, or first admission,

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[6] Brophy, L., and McDermott, F. (2013). "Using Social Work Theory and Values to Investigate the Implementation of Community Treatment Orders." *Australian Social Work*, 66 (1): 72–85.

[7] Corring, D., O'Reilly, R., Sommerdyk, C., & Russell, E. (2019). The lived experience of community treatment orders (CTOs) from three perspectives: A constant comparative analysis of the results of three systematic reviews of published qualitative research. *International Journal of Law and Psychiatry*, *66*, 101453.

and also people without histories of patterns of persistent readmission, homelessness and serious harm[8]. Although the Act tried to address this there does not seem to have been the expected decreases in the number of people on CTOs and this net widening – which is also apparent in other countries that have CTOs – has persisted[9,10,11]. This relates to the evidence that there is a 'lobster pot' effect with CTOs – in other words it is easy to get on a CTO but much harder to get off one. If a person is doing well – it must be the CTO – if a person is not doing so well – they might be kept on the CTO regardless[12].

16 There are other major ethical problems with CTOs and everyday injustices that people on CTOs experience. For example, in some services people are required to pay for their medication. While for most people this is a small payment, it still seems to be a significant breach of people's human rights as well as an ethical problem. What justification is there for forcing people to pay for a medication produced by a private pharmaceutical company that they are not willing to consent to? This relatively recent phenomena further complicates and compounds the fundamental ethical concerns regarding CTOs. It is also inconsistently applied in that some people on CTOs are exempted from paying for their medication. I consider that people on CTOs should be universally exempted from paying for medication. Similarly, people on CTOs should be able to have out of work hours appointments if they have a job and they should not have to incur any other expenses associated with being forced to attend appointments, such as hospital car parking fees and public transport costs. Current mental health service providers in Victoria appear to have become so complacent about the frequent use of CTOs that these everyday injustices seem to be ignored or minimised.

17 For family and carers, I consider there is a benefit of compulsory treatment because they observe their loved ones accessing and obtaining treatment for their mental health. Ruth Vine and Angela Komiti's research[13], Deborah Corring from Canada[14] and my own

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[8] Brophy, L. M., Reece, J. E., & Mcdermott, F. (2006). A cluster analysis of people on Community Treatment Orders in Victoria, Australia. *International Journal of Law and Psychiatry*, *29*(6), 469–481.

[9] Geller, J. L., Fisher, W. H., Grudzinskas, A. J., Clayfield, J. C., & Lawlor, T. (2006). Involuntary outpatient treatment as "desintitutionalized coercion": The net-widening concerns. *International Journal of Law and Psychiatry*, *29*(6), 551–562.

[10] Morandi, S. 2016. Descriptive and epidemiological studies. *In:* Molodynski, A., Rugkåsa, J. & Burns, T. (eds.) *Coercion in Community Mental Health Care: International Perspectives.* Oxford: Oxford University Press.

[11] Bardell-Williams, M., Eaton, S., Downey, L., Bowtell, M., Thien, K., Ratheesh, A., ... & O'Donoghue, B. (2019). Rates, determinants and outcomes associated with the use of community treatment orders in young people experiencing first episode psychosis. *International Journal of Law and Psychiatry*, 62, 85-89.

[12] Morandi, S. (2016). Descriptive and epidemiological studies. *Coercion in Community Mental Health Care: International Perspectives.*

[13] Vine, R., & Komiti, A. (2015). Carer experience of Community Treatment Orders: implications for rights based/recovery-oriented mental health legislation. *Australasian Psychiatry*, *23*(2), 154–157.

[14] Corring, D., O'Reilly, R., Sommerdyk, C., & Russell, E. (2019). What families have to say about community treatment orders (CTOs). *Canadian Journal of Community Mental Health*, 37(2), 1-12.

research[15, 16] confirms this. Compulsory treatment may also release families or carers from feeling like they need to monitor whether a person is taking their medication and attending appointments because mental health services are supervising the treatment. However, I also qualify this because families and carers are often also concerned about compulsory treatment because they see some of the harms that are attached to compulsory treatment orders. These harms include family members witnessing a person being forced to take often large doses of medication via depot injection that often result in unpleasant side effects, and treatment being restricted to a biomedical approach rather than a more holistic recovery-oriented approach. It may even reinforce problems in families if compliance with medication becomes over emphasised. For example, I had a participant in one study who described the negative impact of their family insisting that they do what the staff said – even when this seemed unreasonable - such as being forced to take night time medication earlier in the day to suit the workers timetable rather than at their usual bedtime.[17] Hence an unintended consequence may be that a CTO encourages discriminatory and objectifying thinking and behaviour by families.

18 In my view, we have not explored alternate ways to support families from a psycho-social perspective. Issues related to family dynamics and relationships (such as arguments, disagreements and tensions at home and issues around family violence) may be related to the deterioration in a person's mental health such that it is considered that a CTO is required. In order to address recovery for persons requiring compulsory treatment, I consider it important that underlying social and relationship factors be explored around mental health rather than relying on medication as the primary, and sometimes only, treatment. There is excellent evidence for the value of working with families[18] but very poor uptake and this seems to be the case in relation to people on CTOs.

19 The evidence on whether compulsory community treatment benefits the health system is, at best, mixed. Segal and colleagues have analysed data from Victoria and found that for individuals at risk of long-term psychiatric hospitalisation, the use of CTOs appeared to prevent additional hospitalisation. They therefore argue that CTOs provide a less restrictive alternative to hospitalisation[19, 20]. In contrast, a Cochrane review found no

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[15] Brophy, L. M., Kokanović, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community Treatment Orders and supported decision making. *Frontiers in psychiatry*, 10, 414.

[16] Brophy, L., and McDermott, F. (2013). "Using Social Work Theory and Values to Investigate the Implementation of Community Treatment Orders." *Australian Social Work* 66 (1): 72–85.

[17] Brophy, L. M., Kokanović, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community Treatment Orders and supported decision making. *Frontiers in psychiatry*, 10, 414.

[18] Hayes, L., Brophy, L., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry*, 26(6), 578-585.

[19] Segal, S.P. and Burgess, P. (2009). Preventing psychiatric hospitalization and involuntary outpatient commitment. *Social Work in Health Care*, *48,* 232–242.

[20] Segal, S.P., Hayes, S.L., Rimes, L. (2017). The utility of outpatient commitment: I. A need for treatment and a least restrictive alternative to psychiatric hospitalization. *Psychiatric Services 68*, 1247-1254.

evidence, based on randomised controlled trials, that CTOs reduced health service use, including no evidence of preventing readmissions, number of readmissions, or bed days.[21] Further, this review found that CTOs achieved no improvement in social functioning, mental state, quality of life or satisfaction with care compared with standard care, although people on CTOs were less likely to be victims of non-violent crimes. As indicated previously, the literature persistently suggests that if CTOs do provide benefit it may be because they act as an administrative mechanism signalling a need for access to care in a system that fails to respond appropriately in a voluntary capacity[22].

20 The most recent paper for the UK addressing this issue[23] published as recently as April 2020, found that people were on CTOs for much longer than policy makers in the UK had anticipated (3.5 years as opposed to the 9 months initially predicted), had a significantly lower mortality rate, had greater rates of readmission and spend longer in psychiatric hospital than patients who were not on CTOs. They also found that black and minority ethnic groups are over-represented. These are very interesting findings that continue the debate about why CTOs are being used and what outcomes are being achieved.

Question 3: Are there other alternative methods to compulsory treatment to engage people in treatment? If so:

a. what are they?

b. what factors needs to be present in an individual for these methods to work?

c. what features or circumstances need to be present at a systemic level for these methods to work?

d. to what extent could these methods be replicated or used more widely in Victoria?

21 Non-coercive alternatives to CTOs, such as decision-making supports and improvements in treatment and service provision must be explored. Providing advocacy, giving people greater choice and control and other strategies to empower people helps to engage

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[21] Kisely, S., Campbell, L.A., and O-Reilly, R. (2017). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews.* Available at

http://onlinel brary.wiley.com/doi/10.1002/14651858.CD004408.pub3/full.

[22] Newton-Howes, G., and Ryan, C. J. (2017). The use of community treatment orders in competent patients is not justified. *The British Journal of Psychiatry, 210*(5), 311-312.

[23] Barkhuizen, W., Cullen, A. E., Shetty, H., Pritchard, M., Stewart, R., McGuire, P., & Patel, R. (2020). Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study. BMJ open, 10(3), e035121.

people in treatment, enhance personal recovery and represent alternatives to compulsory treatment[24].

22 We need to continue to support improved uptake of advance statements. These and other ways of supporting a person's decision-making are favoured by many service users[25]. While the efficacy of these tools is only now beginning to be examined, de Jong et al. conclude that there is greater evidence for the effectiveness of advance statements in reducing compulsory admissions than there is for CTOs[26].

23 I consider that supporting people in a more intensive and holistic way should be considered as an alternative to the system's tendency to seek that people be compulsorily treated and medication being primarily relied on as the only form of treatment. As part of this we need to have an open and frank discussion about the limitations of medication. It appears that some people only achieve limited benefit from medication and persistently relying on CTOs to achieve medication 'compliance' and prevent relapse and readmission may be a barrier to the potential to develop more innovative, personal centred approaches. A recent study has highlighted how a CTO and medication may be addressing clinical issues but not personal recovery outcomes or functional gains – that is getting people back into work, education and improving their social connections [27].

24 Pat Bracken and 28 colleagues from around the world have all agreed that psychiatry needs to embrace the evidence that personally meaningful recovery from serious mental disorder is not necessarily related to the specific treatments that are prescribed.[28] Alternatively, research supports the importance of the therapeutic alliance, enhancing people's self-esteem and an 'internal locus of control' in determining outcomes. To follow this logic, we need a therapeutic context that promotes empowerment and connectedness and that helps rebuild a positive self-identity, an approach that is potentially at odds with reliance on compulsory treatment.

25 In my view, we have prioritised a dominant paradigm of a medical model, emphasising pharmacological interventions, symptoms, diagnosis and clinical recovery, and have lost perspective on how other fundamentally important social determinants need to be

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[24] de Jong, M. H., Kamperman, A. M., Oorschot, M., Priebe, S., Bramer, W., van de Sande, R., ... & Mulder, C. L. (2016). Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis. *JAMA psychiatry*, 73(7), 657-664.

[25] Henderson, C., Swanson, J. W., Szmukler, G., Thornicroft, G., & Zinkler, M. (2008). A typology of advance statements in mental health care. *Psychiatric Services*, 59(1), 63-71.

[26] Ibid.

[27] Bardell-Williams, M., Eaton, S., Downey, L., Bowtell, M., Thien, K., Ratheesh, A., ... & O'Donoghue, B. (2019). Rates, determinants and outcomes associated with the use of community treatment orders in young people experiencing first episode psychosis. *International Journal of Law and Psychiatry*, 62, 85-89.

[28] Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., ... & Downer, S. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201(6), 430-434.

addressed in order to respond to or prevent mental illness and its deterioration. We need to acknowledge the links between people being compulsorily treated and the social determinants of health. For example, there is recent evidence from the UK that the people most likely to be treated compulsorily are from disadvantaged or marginalised socio-economic backgrounds and culturally and linguistically diverse backgrounds [29, 30]. Similar research from Queensland suggests that Indigenous people are more likely to be compulsorily detained in hospital or on a CTO [31]. Another example, again from research in Queensland, found that culturally and linguistically diverse consumers who needed interpreters were placed on CTOs at nearly triple the rate compared with Australian born, English speaking consumers [32]. Accordingly, when I speak to alternatives, I consider that factors like safe and affordable housing, the experience of stigma and discrimination-including racism- and the implications of people living in poverty should be considered.

26 In building alternatives, evidence based psychosocial interventions, and their uptake, should be a focus. Alternative models of care have the potential to reduce the use of compulsory treatment. For example, the housing first model[33] has empirically had very positive results[34] and enabled people to access safe and secure housing and then build supports around them. This may be a better strategy in the long term than putting someone on a compulsory treatment order.

27 We also need services that are more attractive, accessible, easier to navigate and work harder to meet the goals and aspirations of the people seeking help. Furthermore, we need to minimise the risk that these very same services contribute to people experiencing trauma, stigma, discrimination and poor outcomes. Rethinking what we see as a “good” outcome might be an important place to start. Our priority should be on service delivery

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[29] Walker, S., Mackay, E., Barnett, P., Sheridan Rains, L., Leverton, M., Dalton-Locke, C., ... Johnson, S. (2019). Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis. *The Lancet Psychiatry*, *6*(12), 1039–1053.

[30] Brophy, L., Roper, C., & Grant, K. (2019). Risk factors for involuntary psychiatric hospitalisation. *The Lancet Psychiatry*, *6*(12), 974–975.

[31] Kisely, S., Moss, K., Boyd, M., & Siskind, D. (2020). Efficacy of compulsory community treatment and use in minority ethnic populations: A statewide cohort study. *Australian & New Zealand Journal of Psychiatry*, 54(1), 76–88.

[32] Moss, K., Wyder, M., Braddock, V., Arroyo, D., & Kisely, S. (2019). Compulsory community treatment and ethnicity: Findings from a culturally and linguistically diverse area of Queensland. *International Journal of Law and Psychiatry*, 62, 154–159.

[33] A model that began in the United States in the early 1990s that secures safe and permanent housing as a first priority for people experiencing homelessness. Once housing is secured, a multidisciplinary team of support workers (for example, drug and alcohol counselling or mental health treatment) work with the person to address complex needs and their recovery and integration within the community. This model has additionally been taken up by various European countries, in Canada and New Zealand.

34 Somers, J. M., Moniruzzaman, A., Patterson, M., Currie, L., Rezansoff, S. N., Palepu, A., & Fryer, K. (2017). A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats. PLoS ONE, 12(1), e0168745.

being genuinely linked to the overarching legal and policy frameworks[35] currently guiding mental health practice – in particular recovery oriented practice, trauma informed care and supported decision making[36]. Furthermore, co-production and co-design has an important role to play by enabling the voice of consumers to be heard and informing service development[37]. Co-production requires us to rethink the current power dynamics and move towards valuing lived experience expertise in identifying what is working – and what is not.

28 As part of this, I also see value in people on compulsory treatment orders, and those who may be at higher risk of compulsory treatment (such as voluntary patients in inpatient units) having an independent advocate who may or may not be a lawyer. For example, there is empirical evidence from a small study where people in an inpatient setting received access to advocacy from the time they arrived at the hospital and continuing through their care. This led to people being more likely to agree that treatment was necessary and be engaged in a more therapeutic relationship [38]. Similar findings were also achieved by the CRIMSON project in the United Kingdom[39]. This began with a pilot program that saw an independent person come in and facilitate a conversation between a person and their clinicians in formulating a crisis plan. There was great fidelity to this approach in the pilot and it was subsequently funded to undertake a much larger trail. However, this did not get the same significant positive results and it appears to be because there was less fidelity to the approach.

29 An option based on the evidence for the value of independent advocacy is to offer universal advocacy to everyone on a compulsory order from which they could opt out. This could be based on expanding the existing service offered currently by the Independent Mental Health Advocacy Service[40]. The most important features of the service are to be independent from the mental health service but have specialist knowledge and skills. It may also be an excellent role for our expanding mental health

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[35] Commonwealth of Australia. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Canberra Australia: The Commonwealth of Australia Retrieved from https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/fifth-plan.

[36] Davidson, G., Brophy, L., Campbell, J., Farrell, S. J., Gooding, P., & O'Brien, A.-M. (2016). An international comparison of legal frameworks for supported and substitute decision-making in mental health services. *International Journal of Law and Psychiatry*, *44*, 30–40.

[37] Daya, I., Hamilton, B., & Roper, C. (2020). Authentic engagement: A conceptual model for welcoming diverse and challenging consumer and survivor views in mental health research, policy, and practice. *International Journal of Mental Health Nursing*, 29(2), 299-311.

[38] Rosenman, S., Korten, A., & Newman, L. (2000). Efficacy of continuing advocacy in involuntary treatment. *Psychiatric Services*, *51*(8), 1029-1033.

[39] Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., ... & Lester, H. (2013). Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *The Lancet*, 381(9878), 1634-1641.

[40] Weller, P., Alvarez-Vasquez, S., Dale, M., Hill, N., Johnson, B., Martin, J., ... Thomas, S. (2019). The need for independent advocacy for people subject to mental health community treatment orders. *International Journal of Law and Psychiatry*, 66, 101452.

peer support workforce or at least be conducted by teams that include peer support workers/people making intentional use of their lived experience.

30 Another alternative, is enhancing critical time intervention and intensive community treatment or outreach (including home based treatment) for people who are experiencing a deterioration in their mental health or experiencing a difficult transition from inpatient services to the community. This is a focus on preventing a person suffering an acute deterioration in their mental health and reduce the need and/or basis for the making of a CTO. For example, rather than a CTO being made for a person being discharged from an inpatient setting, this period could be seen as a transition period where assertive community treatment and support is required. To that, I would reiterate the need to incorporate the peer support model into community treatment, where people requiring treatment are paired up with a peer support worker who has their own lived experience of mental health services. Again, there is good evidence internationally and locally for this post discharge peer support [41] [42] [43].

31 The key to any of this work – advocacy, supported decision making mechanisms, particularly advance statements, intensive community care and peer support - is a trusted person who provides continuity, demonstrates skilful communication, engages with supported decision making, is focused on strengths and personal recovery and undertakes work that is inclusive of individuals and, with the person's agreement, their families, friends and other supporters.

32 To exemplify the need for responsive, person centred intervention for people experiencing a deterioration in their mental health, I was involved in a project where a file audit was conducted for people who had their CTOs revoked under the 1986 mental health legislation [44]. We reviewed the reasons why the person's CTO was revoked (or in current language "varied") and they were forcibly sent back to hospital. It appeared that often the person's stability and treatment was disrupted for some reason (for example, they experienced a loss or had a change of treating team etc). As a result of this disruption, the file notes would tend to indicate that a person's mental state was deteriorating, but it appeared that no additional sessions or intensive treatment was then offered by the community mental health service. Sadly, the common trajectory was that the person's mental health would deteriorate to the point that the CAT team would be

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[41] Lawn, S., Smith, A., & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *Journal of Mental Health*, 17(5), 498-508.

[42] Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., ... & Sullivan, S. (2018). Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. *The Lancet*, 392(10145), 409-418.

[43] Scanlan, J. N., Hancock, N., & Honey, A. (2017). Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalisation. *BMC psychiatry*, 17(1), 307.

[44] Owens, N., & Brophy, L. (2013). Revocation of Community Treatment Orders in a mental health service network. *Australasian Psychiatry*, *21*(1), 46–50.

called to intervene, and an assessment would be made as to whether emergency treatment was required. At this stage, people were often transported to the emergency department by the CAT team or other emergency service providers (police or ambulance) and a revocation (or variation to inpatient) was sought. Once they were admitted into hospital, the person would be treated by an entirely new treating team with no continuity of care being considered. The involvement of the police and the trauma and distress associated with this seemed to not be addressed and discussed with the person and their family.

33 In conclusion we found:

> *Revoking [now varying] a patient's CTO and involuntary admission to hospital was regarded as a very significant and serious infringement of people's liberty, as well as their dignity, but there was a sense that the distress, shame or trauma resulting from this process was given minimal attention. This applied particularly to situations where police were in attendance and, to a lesser extent, when an ambulance attended the person's home. (p.49)*

34 Here we see an example of people being potentially harmed by the trauma associated with coercion and compulsory treatment that might have been avoided with more emphasis on a person centred concertinaing of services – in other words – expanding and contracting as required in order to ensure a timely response to changes in the person's needs [27]. This approach requires staff who are highly skilled and able to take a recovery oriented approach, as well as adequate resourcing of community based services.

35 In considering alternatives to compulsory treatment, the mental health system must gain access to information about new models of care, innovations or even changes that could support the models of care that are already in existence[45]. Often when implementing new models of care, the model is corrupted by the impact of having insufficient resources to properly analyse its impacts and see it flourish. New innovations must be supported on a continued basis, so they can be given the opportunity to operate as intended. For example, I am currently conducting an extensive research project about Prevention and Recovery Care services (**PARCs**) (where people are provided intensive residential support for up to 28 days in an aid to transition back to the community or to avoid hospital)[46]. The preliminary data suggests that entry into PARCs reduces the amount of

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[45] Kakuma R, Hamilton B, Brophy L, Minas H, Harvey C. Models of Care for people with severe and enduring mental illness: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health, 2017 https://www.saxinstitute.org.au/wp-content/uploads/MoC-severe-and-enduring-mental-illness.pdf

[46] Fletcher, J., Brophy, L., Killaspy, H., Ennals, P., Hamilton, B., Collister, L., ... Harvey, C. (2019). Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria. *Frontiers in Psychiatry*, *10*, 735.

time that a person is on a compulsory treatment order and on this basis, I would advocate for an ongoing commitment to fund PARCs and other innovations highly regarded by consumers (such as recovery colleges)[47] [48], so that we can develop innovative treatment models and service delivery that have the consequence of people spending less time in hospitals and on compulsory treatment orders, and achieve their recovery goals.

36 Another consideration is the potential for access to individualised, person centred support through the National Disability Insurance Scheme (**NDIS**) which may eventually have an impact of reducing the need for compulsory treatment. We need to carefully monitor if people on compulsory orders are gaining access to the NDIS and then what impact having NDIS support offers. I am very optimistic about the possibilities here, but this depends on every effort being made to ensure that people on compulsory treatment orders who are eligible for the NDIS gain access and are supported through the process required to obtain a support package.

37 Developing models, such as mental health peer support workers being included in emergency departments and alternative crisis services such as the Safe Haven at St Vincent's Hospital, are also very promising ways of trying to reduce the use of restrictive interventions and compulsory treatment orders[49]. However, unfortunately, our opportunities for innovation are currently limited, particularly if available resources are directed to services that provide compulsory treatment, like inpatient units.

Question 4: In Victoria, the Mental Health Act 2014 (Vic) states that the compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration in the person's mental or physical health or to prevent serious harm to the person or to another person.

a. Are there other factors that influence how clinicians may seek to use compulsory treatment? Please consider the impacts, if any, of resource constraints within the current mental health system.

38 To begin, there is an assumption in these questions that compulsory treatment does prevent a serious deterioration. However, it should be noted, as discussed above, that compulsory treatment orders are not always effective. Indeed, some consumer narratives describe negative care experiences and compulsory treatment making them worse rather than better. This includes issues such as, medications not leading to any substantial

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[47] Crowther, Taylor, Toney, Meddings, Whale, Jennings, ... Slade. (2019). The impact of Recovery Colleges on mental health staff, services and society. *Epidemiology and Psychiatric Sciences*, 28(5), 481–488

[48] Hall, T., Jordan, H. L., Reifels, L., Belmore, S., Hardy, D., Thompson, H., & Brophy, L. (2018). A process and intermediate outcomes evaluation of an Australian recovery college. *Journal of Recovery in Mental Health*, 1(3), 7-20.

[49] Chavulak, J., L. Buckley, and M. Petrakis, Recovery co-design and peer workforce development in the acute inpatient setting. New Paradigm, 2018. Summer 2017/18: p. 34-39.

improvement, debilitating side effects, feeling demoralised, traumatised and afraid or distrustful of services[50]. So, any discussion of why and how compulsory treatment is used needs to be mindful of contested views about its benefits.

39 I consider there are other factors that influence how clinicians may seek to use compulsory treatment. In my view, as discussed above, clinicians may apply for compulsory treatment orders as a means of guaranteeing treatment and service delivery for a person. Further, a person can often be locked into a situation of compulsory treatment, if that person is not receiving community based support and treatment and does not have resources (such as stable housing), does not have informal supports and does not have good relationships within their family. Hence viable alternatives may seem elusive and a compulsory order becomes a first rather than last resort.

40 Further, reports that are provided to the Tribunal often deal with information about historic matters around a person's mental health and issues relating to past risk. Clinicians are often risk averse and worried that they will be 'blamed' if they do not recommend compulsory treatment and subsequently an adverse incident occurs. Hence it can be difficult for staff to make the shift to recovery oriented practice. I discuss issues around risk further at paragraph 61 below.

41 The points I have raised above have relevance to the Principles Unite Local Services Assisting Recovery project (**PULSAR**)[51]. The PULSAR project provided an opportunity to undertake an adaptation of the REFOCUS intervention developed in the UK[52], in collaboration with the REFOCUS investigators, in a way that considered the unique, diverse and complex Australian context for adaptation of Recovery principles, tools and methods. We undertook four years of dedicated research work (2014 – 2018) funded by the Victorian Government's Mental Illness Research Fund ($2.2 million). We trained 192 mental health-care workers from 3 partner agencies and generated the only study internationally to demonstrate the positive impact of this training on consumer rated recovery outcomes[53]

42 The positive results of the study make an important contribution to planning for ongoing innovation and service improvement in Victoria, Australia and internationally. On the basis

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[50] Daya, I., Hamilton, B., & Roper, C. (2020). Authentic engagement: A conceptual model for welcoming diverse and challenging consumer and survivor views in mental health research, policy, and practice. *International Journal of Mental Health Nursing*, 29(2), 299-311.

[51] Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., ... & Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. *The Lancet Psychiatry*, 6(2), 103-114.

[52] Slade, M., Bird, V., Clarke, E., Le Boutillier, C., McCrone, P., Macpherson, R., ... & Leamy, M. (2015). Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial. The Lancet Psychiatry, 2(6), 503-514.

[53] Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., ... & Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. *The Lancet Psychiatry*, 6(2), 103-114.

of our findings we have previously recommended that the Victorian government invest in recovery oriented practice training using the now evidence based PULSAR training.

43 PULSAR training:

(a) utilised a mixed-methods stepped-wedge cluster randomized control trial design to evaluate whether adults accessing secondary and primary care mental health services, where staff received purposely developed recovery-oriented practice (ROP) training, reported superior recovery outcomes compared to those accessing services where staff had not received this training. Several nested qualitative studies were also undertaken to understand the experiences of consumers and staff from the services where this training was provided. We were aware that much of the literature and policy was silent about how to apply ROP in the context of CTOs and in our training.

(b) was delivered by a multi-disciplinary team from Monash University, Monash Health, Mind Australia, Ermha and included content experts in coaching and consumer perspective. 190 staff were trained, so a total 63% of eligible staff attended. Medical staff specific training was attended by 11 registrars.

(c) offered monthly sessions to staff of involved teams to support practice-based implementation of ROP – the PULSAR Active learning sessions (PALS). The average number of PALS during the time we were doing the research was 8.1 sessions.

(d) Included a manual. The manual included material on connectedness, hope, identity, meaning and empowerment (CHIME) as a conceptual framework and added material on relapse signatures and relapse drills. The manual also we addressed this issue and provided guidance for ROP with people on CTOs[54] to address ROP in training. When we adjusted the REFOCUS intervention, we took into account a situation where approximately 25% of people accessing clinical mental health services are on Community Treatment Orders (CTOs).

44 The results of this large research project suggest that the REFOCUS-PULSAR intervention can lead to an overall measured improvement in personal recovery, also possibly with some effect on measures of clinical recovery and other aspects of the experience of the participants who accessed the intervention services.

45 We also found the training assisted clinicians to be less risk averse and more recovery oriented. As one staff participant said: *As much as I hate to say it, that's kind of what you have to do in a lot of ways, stand up against risk aversion and promote dignity of risk and*

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[54] https://www.monash.edu/medicine/scs/psychiatry/research/southern-synergy/health-services/pulsar

taking chances and giving people opportunities. I guess it (PULSAR) empowered me to really take that on in a more real way (S2)[55].

46 I consider that clinicians must be very careful to focus on a person's current progress, issues and goals rather than a heavily weighted negative focus on a person's history. This relates to a focus on personal recovery and not just clinical recovery and the reduction of symptoms. Personal recovery encourages a focus on connection, hope, identify meaning and purpose and empowerment – this can be considered incompatible with compulsory treatment, especially prolonged compulsory treatment. In the PULSAR project staff "*expressed feeling powerless to make change happen and were waiting for 'the service' to make the changes necessary to support them to implement recovery oriented practice"* (p.182)[56].

Question 5: To what extent are the existing safeguards contained in the Mental Health Act 2014 (Vic) (including advance statements, nominated persons and the second opinion scheme) as well as current non-legal advocacy and legal representation arrangements:

a. reflective of contemporary practice and evidence?

b. compatible with international conventions on human rights?

c. operating as intended?

d. currently taken up by people who use mental health services?

e. currently taken up by families and carers?

f. currently considered in practice by clinicians when determining assessment and temporary treatment orders?

g. currently considered by the Mental Health Tribunal when determining treatment orders?

47 One of the most important initiatives we can take in mental health service delivery is to shift from substitute decision making and compulsory treatment to supported decision making in line with the principles of the Act. This requires us to presume people have the capacity to make their own decisions about their treatment and care and provide them with any supports necessary to express their views and preferences and ensure that

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[55] Edan, V., Brophy, L., Weller, P. J., Fossey, E., & Meadows, G. (2019). The experience of the use of Community Treatment Orders following recovery-oriented practice training. *International Journal of Law and Psychiatry*, 64, 178-183.p. 181.

[56] Ibid.

these are respected. Based on research I have undertaken with my colleagues[57], I consider that legal mechanisms to enable supported decision making available under the Act as safeguards (such as advance statements) cannot be successful on their own without additional measures being in place. For example, people with mental illness need to be educated that these legal safeguards are available to them. Staff also require advanced interpersonal skills, including sophisticated engagement and negotiation skills, that enable them to have the conversations required to assist people to express their views and preferences and use the legal mechanisms available to them. Leaders and managers in mental health services need to prioritise this work and support the implementation of these mechanisms as required. As a possible result of these additional measures not being in place, I consider there will be a persistent problem of insufficient uptake of these legal safeguards available under the Act. This is unfortunate because, when I see an advanced statement as a Tribunal member, I consider it very valuable when assessing applications for compulsory treatment orders.

48 I consider we should work on, and enable, supports to be put in place to increase the potential for uptake of these mechanisms. A key to this is to work is empowering consumers to gain access to the resources and information they need. Again, independent advocacy, support from consumer led organisations such as VMIAC, peer support, as well as online resources and accessible information are essential. Expecting staff to provide rights information has already been established to be very unreliable[58]. However, we have produced guidelines from our research that provide more detail about the above and the Tribunal are doing some great work to provide training and information sessions to staff to support them in changing practice. We need more investment in these efforts. Supported decision making is strongly linked to recovery oriented practice and trauma informed care. Again, through the PULSAR project, we have evidence that through investing in recovery oriented practice training for staff in mental health services and GPs we can improve recovery outcomes for consumers – and this potentially extends to people on CTOs.[59] [60] [61]

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[57] Kokanović, R., Brophy, L., McSherry, B., Flore, J., Moeller-Saxone, K., & Herrman, H. (2018). Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners. Australian & New Zealand Journal of Psychiatry, 52(9), 826-833.

[58] Weller, P., Alvarez-Vasquez, S., Dale, M., Hill, N., Johnson, B., Martin, J., ... Thomas, S. (2019). The need for independent advocacy for people subject to mental health community treatment orders. *International Journal of Law and Psychiatry*, *66*, 101452.

[59] Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., ... Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial. *The Lancet Psychiatry*, *6*(2), 103–114.

[60] Edan, V., Brophy, L., Weller, P. J., Fossey, E., & Meadows, G. (2019). The experience of the use of Community Treatment Orders following recovery-oriented practice training. *International Journal of Law and Psychiatry*, *64*, 178–183.

[61] PULSAR Manual, Second edition (2016) Monash University:
https://www.monash.edu/__data/assets/pdf_file/0017/1452410/PULSAR-Secondary_Care_Manual-FINAL.pdf

49 In relation to second opinions specifically, I often recommend to people that they should access a second opinion in the Tribunal setting. I have always considered that a second opinion has the potential to be helpful for all involved. However, I have seen problems with second opinions. Firstly, the uptake of second opinion reports is low and where they are used, there are often delays in the receipt of the reports. Also, they may not be written in a way that is readily understood by a consumer. As such, I consider there could be work around improving the second opinion process and to increase the uptake of second opinions. I consider we need to go back to thinking about the purpose of a second opinion and how it can benefit a person. The benefits may range from the person feeling heard all the way through to establishing that a compulsory treatment order is not required, or a misdiagnosis has taken place.

50 Another consideration that may require exploration from a safeguarding point of view, is whether we need the Tribunal to hold special hearings when people have been on compulsory treatment orders for a long period of time. For example, for two years on a CTO and for one year on an inpatient treatment order. This could include special efforts to ensure the person has an advocate who has the time and resources to assist the person to understand their rights and participate in the hearing. There could be increased expectations that important stakeholders attend the hearing, including family, other service providers and the consultant psychiatrist. The outcome of the hearing could be a much more detailed plan focused on moving to a less restrictive treatment option if the person is not discharged.

Question 6: Do current independent oversight mechanisms governing the use of compulsory treatment need to be improved?

a. If so, how?

b. What is required to ensure any changes are successfully implemented?

51 Yes, I agree that current independent oversight mechanisms governing the use of compulsory treatment need to be improved. I consider the Tribunal has had a strong place in providing oversight in relation to the making of compulsory treatment orders to ensure that only people who meet the criteria under the Act can be compulsorily treated. However, the Tribunal is unable to comment on, or supervise, the quality of care or specific treatment that a person is receiving under those compulsory orders and does not have a role in ensuring mental health services are committed to shifting away from compulsory treatment. For example, the Tribunal can say that every effort needs to be made to move a person to a less restrictive treatment option but cannot direct what kind of less restrictive treatment options should be considered. I am not necessarily advocating that the Tribunal should provide this level of oversight, but I certainly consider that a role should be created to ensure that mental health services are being monitored and held

accountable to ensure that less restrictive forms of treatment are being offered to consumers. More oversight is needed to ensure that less restrictive options are consistently explored, regardless of the local health service culture.

52 I consider improved data collection around the numbers of compulsory treatment in Victoria will provide another oversight mechanism. I discuss this in further detail at paragraphs 71-74.

Question 7: To what extent, if any, should compulsory treatment be used in Victoria's future mental health system?

a. Why or why not should compulsory treatment be used in Victoria's future mental health system?

53 I think compulsory treatment is likely to continue to be used in Victoria's future mental health system, but I also think we have the potential to significantly reduce its use.

54 Many mental health practitioners seem to see the abandonment of substitute decision-making and compulsory treatment as farfetched, unrealistic and potentially harmful and therefore do not share the same perspective as national policy and the UN Convention on the Rights of Persons with Disabilities (**CRPD**) in identifying enforced treatment as a violation of an individual's integrity and doing harm.[62] However, as McSherry and Maker[63] have suggested, a way forward may be to is to emphasize that people with mental health challenges are treated as "rights holders" (p. 319), people who have the right to the dignity of risk and a high quality of care that respects and upholds their human rights.

b. From your perspective, if compulsory treatment is to continue, which services and settings should be permitted to use compulsory treatment?

55 In my view, there cannot responsibly be an immediate step away from compulsory treatment without ensuring that there are alternatives in place. Research conducted by Dr Edwina Light from the University of Sydney, points to a reduction in the number of CTOs in Victoria.[64]. While the lower rate observed in this study might be encouraging, this is also occurring in the context of Victoria's public mental health services falling behind other states in relation to funding[65]. Given my comments in paragraph 14 above,

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[62] Brophy, L. (2019). Legal Provisions, Advocacy and Empowerment. In R. Ow, & A. Poon (Eds.), Mental health and social work (pp. 1-20). Singapore: Springer Nature Singapore Pte Ltd. Retrieved from https://doi.org/10.1007/978-981-13-0440-8_18-1.

[63] McSherry B, Maker Y (2018) International human rights and mental health: challenges for law and practice. *J Law Med* 25(2):315–319 (p.319)

[64] Light, E. (2019). Rates of use of community treatment orders in Australia. *International Journal of Law and Psychiatry*, *64*, 83–87.

[65] Vine, R., & Judd, F. (2019). Contextual issues in the implementation of mental health legislation. *International Journal of Law and Psychiatry*, *62*, 16–19.

there is a concern that in circumstances where compulsory treatment orders are made to guarantee treatment and service delivery, we may prevent people receiving the treatment they require in an aid to reduce compulsory treatment rates. As such, I consider that if compulsory treatment rates were to be reduced in Victoria, we need to first build up, and monitor, alternatives to ensure that people are gaining access to treatment and care. I have discussed some of these alternatives at paragraphs 21-27 above.

Question 8: Other than legislation, what are the other ways that could be used to reduce rates of compulsory treatment use? Please consider policy, data collection and dissemination, funding and operational levers.

a. How could they be deployed in Victoria and by whom?

b. What is required to ensure the use of these levers are successfully implemented?

56 In my view, data collection and dissemination will have the effect of informing us about whether there are particular people in the community that are more likely to be treated on a compulsory basis and for how long. We should be investigating the possible reasons why this cohort of people may be more likely to be placed on a compulsory treatment order. The data, and its analysis, will provide the sector with information to understand why compulsory treatment orders have been relied on to some degree in Victoria to provide treatment.

57 In my experience, we have not prioritised people on CTOs and to some extent, it has been normalised within the system that we put people on a CTO so they can be provided depot medication on a regular basis. CTOs are often identified as being incompatible with the shift to recovery-oriented practice and the expectations of Article 12 of the CRPD[66]. They lead to a restriction of human rights, including the rights to liberty and physical and mental integrity, sometimes over many years[67]. I believe we need to prioritise the needs of people on CTOs and ensure they receive the quality of care that is commensurate with the rights they are forced to sacrifice (otherwise known as reciprocity). I consider that this reciprocity may not be achieved in the current system which is taking away people's rights but may not be providing sufficient services, rather, only prioritising pharmacological treatments. For example, if a person is placed on a CTO, a focus on more home-based care and support and intensive treatment could be considered as well as engaging other community support services – including the NDIS. As discussed above mental health

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[66] Convention on the Rights of Persons with Disabilities (CRPD). 2007. (resolution 61/106), opened for signature on 30 March 2007, entered into force into force on 3 May 2008.

[67] Brophy, L., Kokanovic, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community Treatment Orders and Supported Decision-Making. *Frontiers in Psychiatry*, 10, 1-12.

services need to recognise that addressing poverty and disadvantage is legitimately part of core business.

USE OF COMPULSORY TREATMENT IN VICTORIA

Establishing and maintaining effective therapeutic relationships with patients on a compulsory treatment order

58 I consider the following is important in order to establish and maintain an effective therapeutic relationship when a patient is on a compulsory treatment order. This builds on findings from my PhD[68] and more recent recovery oriented practice and supported decision making projects as follows:

(a) Principles for good practice and taking a person-centred approach are significant. A focus on recovery oriented practices are essential so that clinicians can work with consumers towards building on their strengths, achieving their personal goals and getting off a compulsory treatment order. Providing practical support needs to be recognised as a valuable contribution, especially as it might enable a therapeutic relationship. Interpersonal skills – including listening and being compassionate - are the foundations of this work;

(b) Questions and analysis must be posed by a clinician such as: What are the persons views and preferences? What is the purpose of the compulsory treatment order? Why is the person is being placed on such an order? What needs to happen for the person to come off an order? Is there a shared understanding of that? Is that fair? Is that reasonable?;

(c) Addressing social issues including housing stability, income security and loneliness is essential;

(d) A human rights focus – as stated above – emphasising that people with mental health challenges are rights holders and thus have the right to the dignity of risk and a high quality of care that respects and upholds their human rights. This includes the person on the order having access to advocacy, supported decision making and procedural fairness;

(e) Aiming for quality in service delivery – this requires staff, including peer support staff, to have the time and resources to provide the treatment, care and support required; and

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[68] Brophy L, McDermott F (2013) Using social work theory and values to investigate the implementation of community treatment orders. *Australian Social Work* 66(1):72–85.

(f) With the person's permission, the involvement of other people that have a stake in a person's treatment and care (for example, family members and other service providers such as NDIS support workers).

Supports for consumers moving between different types of compulsory treatment orders or being discharged from compulsory treatment orders

59 Continuity of care is an important support for people moving between different types of compulsory treatment orders and when they are discharged from compulsory treatment. It is important to recognise that at times of change and transition; people may require additional support. I also consider that consumers should be given the opportunity to make choices and control their treatment and care and should be supported with their decision-making if required. Understanding a consumers' preferences and their views in relation to transitions in their treatment is key and I consider too often, the needs of the mental health service are prioritised in times of transition rather than the needs of the consumer. For example, a person may be inappropriately discharged into a supported residential service, a boarding house or another form of unsuitable accommodation due to pressure on beds, adding to the difficulties in making a transition and further impeding their ability to engage in treatment.

60 The need for continuity of care requires reducing the rotation of staff, particularly psychiatry registrars. As previously stated, lack of continuity of care is a persistent and dreadful problem for people on CTOs. In the move to an agreement that relationships are central to mental health care then mental health services in Victoria need to reject the current extraordinary tolerance of all of the 'churn' in the system, created by changes in teams and changes of doctor and case manager that people accessing services experience. This results in distress, a lack of relationship building and difficulties in making good decisions about the appropriateness of a CTO. This is currently meeting the needs of training - not the people being served and their families and supporters. Psychiatric registrars may only be in the rotation for six months and may only see patients on a monthly or fortnightly basis, with the consultant psychiatrist seeing a person much less frequently. This interrupts the continuity of care for people requiring psychiatric services and is distressing for the consumer and their families and other members of staff who are constantly required to adjust to new team members.

TREATMENT CRITERIA AND PRACTICE

Appropriateness of the 'serious harm of self or others' threshold for compulsory treatment under the Act

61 I consider that in reformulating the Act, we made every effort to tighten the criteria for the use of compulsory treatment which was appropriate. However, I consider there may be

some inconsistency around how mental health services demonstrate that the potential for harm is serious. Staff need skills in understanding the difference between when a person may make a poor decision for themselves versus a person who genuinely represents a risk to themselves or others. This is related to having respect for 'the dignity of risk' which is supported by the Act's principles that include "Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk" . Evidence suggests that it is not possible to predict, at an individual level, if a person is at high risk of suicide[69]. Assessing the risk of serious violence faces similar problems[70]. There is a body of literature suggesting that risk assessments for harm to self and others may be of limited or no clinical use [71] [72] [73]. In my view, we need to be considering the protective factors for people that may require compulsory treatment, how these protective factors can assist within our decision making and what interventions could be appropriate for the person. For people with minimal or no supports who are living in difficult circumstances, a focus should be on building up their protective factors rather than considering whether they pose a risk of harm to themselves or others and wasting time seeking to make a determination about a level of risk which we are unable to make. Unfortunately, building and working on an increase in protective factors is not currently prioritised due to inadequate resourcing in the mental health system.

SAFEGUARDS

Factors that influence the use of Advance Statements and Nominated Persons in practice

62 As discussed in paragraph 47, I consider that further education is required about the use of advance statements and nominated persons by consumers and clinicians. For clinicians, I also consider that the building of soft or negotiation and interpersonal skills is important in terms of how they speak to consumers about advance statements and nominated persons. I additionally consider that management need to show leadership around the use of advance statements and nominated persons in the clinical context and encourage clinicians to support clients in accessing these safeguards. A reduction in stigma and discrimination around compulsory treatment and having clinicians 'stand more

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[69] Large, M. M., Ryan, C. J., Carter, G., & Kapur, N. (2017). Can we usefully stratify patients according to suicide risk? *BMJ*, 359, j4627.

[70] Szmukler, G., & Rose, N. (2013). Risk Assessment in Mental Health Care: Values and Costs. *Behavioral Sciences & the Law*, 31(1), 125–140.

[71] Paton, M. B., Large, M. M., & Ryan, C. J. (2014). Debate: Clinical risk categorisation is valuable in the prevention of suicide and severe violence – No. *Australasian Psychiatry*, 22(1), 10–12.

[72] Mulder, R., Newton-Howes, G., & Coid, J. W. (2016). The futility of risk prediction in psychiatry. The British Journal of Psychiatry : *The Journal of Mental Science*, 209(4), 271–272.

[73] Ryan, C. J., & Large, M. M. (2013). Suicide risk assessment: where are we now? *Medical Journal of Australia*, 198(9), 462–463.

in the shoes' of a consumer is important. This is discussed in more detail in the guidelines we developed in the supported decision making project[74].

Improvement of safeguards for compulsory treatment

63 I consider that the use of safeguards in relation to compulsory treatment needs to be improved. I have spoken about some of the safeguards that ought to be implemented and improved in paragraphs 47-50 above. But safeguarding can occur at various levels. For example, one safeguard is that all clinicians and lawyers that appear at the Tribunal be prepared and attempt to make a Tribunal hearing a more positive experience when they speak about a person's experience of struggles with their mental health and write reports so not to further traumatise a person. Good and sensitive communication by clinicians may help consumers better understand and accept why a compulsory treatment order has been made and how to move towards voluntary care. This is where I see a need for clinicians in the mental health space to be provided with training to develop advanced soft skills.

INDEPENDENT OVERSIGHT

Effectiveness of existing independent oversight mechanisms under the Act

64 I refer to paragraphs 52-52 in relation to this topic.

65 I would also like to offer my support for the Office of the Chief Psychiatrist, Community Visitors and the Mental Health Complaints Commissioner who are all working with good intentions but remain under resourced and seemingly without the required power to effect much needed change – even though they seem to be acutely aware of the problems. It is interesting to reflect on the continued absence of a comprehensive set of codes of practice, this seems to be a lost opportunity. Codes of practice, developed in collaboration with consumers and carers, may be an excellent opportunity to build expectations about the practice improvements required as discussed above.

Adequacy of oversights and safeguards for consumers in SECU settings

66 I do not have particular experience with SECU settings as my research is mainly based in community environments. However, my observation is that people in SECU environments are often trapped in that setting:- not by issues relating to their mental health necessarily, but more by issues around the social determinants discussed above and a lack of support in relation to psycho-social interventions. Rehabilitation is often not provided or taken up for people in SECU environments even though the empirical

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[74] Brophy L, McSherry B, Kokanovic R et al (2017) Guidelines for supported decision-making in mental health services. University of Melbourne, Melbourne. http://healthtalkaustralia.org/wpcontent/uploads/2017/09/Guidelines-for-Supported-Decision-Making-in-Mental-Health-Services.pdf.

evidence is that psychiatric rehabilitation, alongside recovery-oriented practice, is beneficial to a person in a SECU-type setting. Psychiatric rehabilitation includes interventions such as social skills training, cognitive remediation, individual placement and support for education and employment and family interventions.[75] It is important that oversights and safeguards available for people in SECUs are able to monitor whether SECU consumers are having their recovery goals and rehabilitation needs (which are likely to be interrelated) met. Without this emphasis there is a risk that people in SECU are languishing in a highly restrictive environment.

FUTURE STATE

Potential obligations on the State or mental health services to provide services

67 I consider there should be obligations on the State or mental health services to provide services to minimise mental health impacts at a time of decline rather than using compulsory treatment. I consider the obligation should be to treat people more holistically and to tailor and personalise a specific care plan around a person's needs. For example, I was initially part of the panel for the Multiple and Complex Needs Initiative (**MACNI**) run by the Department of Health and Human Services (**DHHS**) and Department of Justice and Community Safety. That panel enabled us to plan and coordinate services for people with complex presentations in Victoria and attach budgets. In that way, we could address and set a package that was specifically focussed on a persons' needs. This type of personalised approach is now being provided by the NDIS and my experience from being on the MACNI panel was that personalising service delivery to a specific person and providing a support package for their targeted needs, including psycho-social needs, provided positive change for people with multiple and highly complex needs. It also saw them reduce more negative behaviours, address functional impairment and enhanced their stability in other parts of their lives such as housing. I consider this model would be valuable for to minimising the impacts of mental illness on people, especially those who are otherwise at risk of compulsory treatment.

68 As discussed above, Piers Gooding and colleagues have identified several promising opportunities for improving responses that promote supports based on individuals' rights, will and preferences. This could potentially include services provided by the State that are an alternative to compulsory treatment.[76] This includes crisis homes or crisis respite houses and voluntary residential services that are often consumer managed. Step-

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[75] Harvey, C., Brophy, L., Parsons, S., Moeller-Saxone, K., Grigg, M., & Siskind, D. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 50(6), 534-547.

[76] Gooding, P., McSherry, B., & Roper, C. (2020). Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. Acta Psychiatrica Scandinavica.

up/step-down residential programmes such as PARCS in Victoria are also promising options, as well as non-residential alternatives (such as intensive home-based support).

Rates of compulsory treatment

69 I consider that rates of compulsory treatment should be reduced in Victoria. In Victoria, thousands of people are forced to comply with CTOs which is mostly about having to take medication against their will. CTOs were introduced in Victoria under the Act and until recently Victoria was identified as having one of the highest rates of CTO use in the world, with 98.8 per 100,000 population compared, for example, to 30.2 per 100,000 population in Tasmania and 46.4 per 100,000 in NSW[77]. In her most recent analysis of the data available, Edwina Light has now found that rates of CTO use in Australia range from 40.0 per 100,000 population (in Western Australia) to 112.5 per 100,000 (in South Australia) and since the last national survey in 2012, the rates of people subject to CTOs fell in Victoria to 76.4 per 100,000 [78]. However, Victoria's rates remain one of the highest rates in Australia and the rate of use of CTOs in Australia overall remains at the highest in the world [56]. I have discussed in paragraph 19 above, my mixed response to the apparent drop in numbers of people on CTOs in Victoria.

70 I refer to paragraphs 21-37 above in respect of how I consider compulsory treatment could be reduced. Furthermore, publicly available data from Victoria reports that 27% of mental health consumers were on CTOs at Eastern Health, with a similar 26% at an inner city service (The Alfred), while the rate at an outer suburban service (Peninsula Health) was only 11% and in the south western region (South West Health Care), it was 5%[79]. The driving factors underpinning this variance remain unclear but needs to be investigated. Similar large variations have also been found in the use of seclusion and this has been attributed to the impact of organisational culture[80]. This variation suggests a role of "microcultures" in how compulsory treatment and restrictive practices are used. This needs to be addressed potentially both through incentives and sanctions that encourage careful monitoring of these differences and encouraging organisational change.

Data collection, synthesis and publication and the reduction of compulsory treatment

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[77] Light, E., Kerridge, I., Ryan, C., & Robertson, M. (2012). Community treatment orders in Australia: rates and patterns of use. Australasian Psychiatry, 20(6), 478–482.

[78] Light, E. (2019). Rates of use of community treatment orders in Australia. *International Journal of Law and Psychiatry*, 64, 83–87.

[79] Department of Health and Human Services, Adult mental health quarterly KPI report 2018-19, Quarter four https://www2.health.vic.gov.au/Api/downloadmedia/%7B638BFC6F-05FB-4CE9-8B0F-813A7C581F04%7D

[80] VMIAC. (2019). *Seclusion report.* Retrieved from: https://www.vmiac.org.au/wp-content/uploads/Seclusion-Report_VMIAC_Vic-mental-health-hospital-services_APRIL_2019_FINAL.pdf

71 I consider that the collection, synthesis and publication of the use of compulsory treatment can play an important role in reducing the use of compulsory treatment. During a multi-stakeholder symposium on CTOs, hosted by the Melbourne Social Equity Institute in 2017, we identified five potential projects for further research that could play a role in reducing the use of compulsory treatment as follows:

(a) a scoping study on the use of CTOs across jurisdictions, which includes demographic data of those placed on CTOs and rationales for CTO use (as discussed in paragraphs 71-72);

(b) a randomised control trial comparing the use of CTOs with voluntary assertive community treatment and/or other alternatives to CTOs;

(c) a qualitative study exploring personal and cultural narratives from persons placed on CTOs;

(d) a study of the effect of peer advocacy on the use of CTOs; and

(e) the impact of the national recovery framework and human rights principles in legislation on mental health tribunal members' decision-making concerning CTOs.[81]

72 While all five of these projects that could be conducted by independent researchers are important to address, I will focus my comments below on the first point. We need a detailed understanding of the demographic and clinical characteristics of those who are subjected to community treatment orders and the rationales for their use. If we had this data, we would likely be able to identify social determinants of compulsory treatment which could open up opportunities for preventative interventions. Data of this type would also identify what mental health services use or rely on compulsory treatment orders more frequently, enabling us to examine the reasons behind this increased use and the microcultures in those services. Conversely, examining the reasons why a mental health service may have low rates of compulsory treatment may also be of utility. In a recent research proposal we have suggested the following data sources are required to understand the differences in rates of CTOs: administrative data can enable comparisons to be made regarding the sociodemographic and clinical features of people on CTOs, the percentage of people discharged from inpatient units onto CTOs; the number of people placed on a CTO after a first admission or first episode; the number of people placed on a CTO only after an established history of multiple admissions; and the length of time people remain on CTOs. In this research proposal we suggested undertaking a survey on justifications for forced community treatment that would be open to all stakeholders, plus interviews and focus groups, especially with consumers and carers in high and low

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[81] Brophy, L., Edan, V., Gooding, P., McSherry, B., Burkett, T., Carey, S., Carroll, A., Callaghan, S., Finch, A., Hansford, M. and Hanson, S., (2018). Community treatment orders: towards a new research agenda. *Australasian Psychiatry*, 26(3), 299-302.

CTO use services. Data collection would need to be ongoing, because a one-off collection of data would not sufficiently inform us about how rates and patterns of CTO use may change over time.

73 I also consider it important that data collection is not seen as a burden for the workforce and that people in the sector are open to the value and benefits of data collection and research being incorporated into practice. To ensure meaningful information is gathered, every effort must be made to ensure research is designed in a way that will be seen as most relevant to consumers of mental health services and their carers.

74 I consider that data collection may also have an added benefit of ensuring accountability amongst mental health services in relation to compulsory treatment. However, I am conscious to ensure that those working in mental health services do not end up completing more paperwork because to some degree, written accountability mechanisms have the potential to form a barrier towards people spending more time supporting and caring for consumers. Those that work in mental health services also need to be supported to spend time on therapeutic engagement with consumers, as much as supporting data collection, to enable accountability. One should not be at the expense of the other. I consider that currently, accountability measures and immense amounts of paperwork may be impeding time that could be dedicated to treatment, care and support.

Research and the reduction of compulsory treatment

75 In discussing research and how it may relate to the reduction in the use of compulsory treatment, I refer to my response above in relation to data collection and synthesis. I consider that even basic research may play a role in reducing compulsory treatment and would be highly valuable because it will help drive changes in practice and prioritise these changes because they will be evidence informed. Research will also likely have an added benefit of providing a level of oversight and safeguarding in mental health services. Unfortunately, we do not necessarily have the level of research on compulsory treatment readily available. For example, in Victoria, we need empirical evidence around whether people from a CALD background, or lower socio-economic background or who are Indigenous, may be more likely to be on a compulsory treatment order. If we look to other Australian jurisdictions, research from Queensland has found that Indigenous people appear to be placed on CTOs at higher rates compared with other consumers[82], but this is not consistent across jurisdictions[83]. We need more research in Victoria and nationally to establish the social drivers that underpin compulsion. This research may help us to

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[82] Kisely, S., Moss, K., Boyd, M., & Siskind, D. (2020). Efficacy of compulsory community treatment and use in minority ethnic populations: A statewide cohort study. *Australian & New Zealand Journal of Psychiatry*, 54(1), 76–88.

83 Kisely, S., & Xiao, J. (2018). Cultural and linguistic diversity increases the likelihood of compulsory community treatment. *Schizophrenia Research*, 197, 104–108.

shift thinking around how we respond to compulsory treatment order rates if they affect certain population types more than others. Further, research may assist us with prevention strategies. For example, it is possible that equipping staff with better skills for engaging CALD consumers could prevent the potential overuse of compulsion.[84] This could involve simple steps such as ensuring interpreters are used consistently in community mental health services, including in earlier stages of care, before compulsory treatment is being considered.

76 In order to support research being rapidly translated into practice, we need to incorporate academics, people with lived experience and representatives of the workforce in the mental health sector, co-designing and co-producing research and then being involved in the planning, administration and implementation of these projects and together acting on subsequent findings. This collaborative approach is required so the sector understands the origins of the research questions and the benefits of the research. As discussed above, translation of research into practice and implementation of new models of care can be challenging without a broad range of support. A foundation of enacting principles that support collaboration, co-design and co-production[85] will potentially support research findings being incorporated into practice so service delivery is ultimately improved.

Governance and accountability arrangements for local health services and catchments

77 In the past, Victoria had an Office of Psychiatric Services (**OPS**) that used to oversee mental health services across Victoria, rather than the geographical catchment model. Under the OPS-model there was an attempt to have a uniform approach around mental health care and treatment across the State. I consider that the re-establishment of a similar body like the OPS may be beneficial in Victoria because the sector would have direct leadership and state-wide initiatives and priorities could be set and implemented. This body could also oversee compulsory treatment in local health services if catchments were removed.

78 Alternatively, a mental health commission for Victoria could be considered. This could operate in parallel to the Mental Health Complaints Commission and act an as overseeing body with commissioning, regulatory and oversight powers, such as the Mental Health Commission in the Republic of Ireland.

RESTRICTIVE PRACTICES

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[84] Moss, K., Wyder, M., Braddock, V., Arroyo, D., & Kisely, S. (2019). Compulsory community treatment and ethnicity: Findings from a culturally and linguistically diverse area of Queensland. *International Journal of Law and Psychiatry*, 62, 154-159.

[85] https://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0010/2659969/Coproduction_putting-principles-into-practice.pdf

Legislative and policy changes

79 In a search we conducted of local policies and higher-level state and national guidance we found little mention of 'door locking' and other restrictive interventions in policies and procedures in services.[86] By contrast, these key state and national policies devote considerable space to recovery-oriented practice and least restrictive care in principle. As such, we concluded that these overarching policy positions are not always reflected in local policy and practice. When interviewing staff, they have expressed frustration that the rhetoric of recovery-oriented practice does not necessarily translate into any practical guidance for inpatient settings, or the organisational commitment and leadership that is required.

80 When applying a human rights lens, as the CRPD encourages, seclusion and restraint can be seen as violations of bodily integrity and restrictions of liberty and therefore should be prohibited. However, similar to my comments above regarding eliminating the use of compulsory treatment generally in Victoria's future, before there is consideration of eliminating the use of restrictive practices in mental health services, there needs to be an exploration and embedding of alternative practices. One possible consideration could be setting a time limit to allow mental health services to introduce alternative practices and policies to seclusion and restraint before imposing a legislative prohibition on the use of those restrictive practices. As already discussed, supporting the ongoing implementation of the Safewards model, the six core strategies[87], post incident review, improved management and leadership, adjusting staffing profiles, advocacy, peer support and ensuring that the right staff who share the values and principles of this aspiration are employed, are examples of all that needs to be attended to. This needs oversight and accountability mechanisms that ensure progress is made.

Patient characteristics

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[86] Fletcher, J., Hamilton, B., Kinner, S., Sutherland, G., King, K., Tellez, J. J., Harvey, C. and Brophy, L. (2019) 'Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice', *International Journal of Mental Health Nursing* 28:2: 538-50.

[87] These strategies are:
1. 'Leadership towards organisational change'— articulating a philosophy of care that embraces seclusion and restraint reduction;
2. 'Using data to inform practice' — using data in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use;
3. 'Workforce' — developing procedures, practices and training that are based on knowledge and principles of mental health recovery;
4. 'Use of seclusion and restraint reduction tools' — using assessments and resources to individualise aggression prevention;
5. 'Consumer roles in inpatient settings' — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and
6. 'Debriefing techniques' — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience.
https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

81 Research I have undertaken with consumers and carers appears to suggest that from a consumer-perspective, restrictive practices are often used as a first resort, not a last resort, particularly for people who may have problematic drug and alcohol issues as well as mental health issues [88].

Service operating models

82 Whilst I think generally there is much more current awareness about the difficulties associated with restrictive practices and there are efforts to reduce seclusion and restraint, data on this issue might be of utility.

83 The introduction of Safewards in Victoria has been making an important contribution to reducing restraint and seclusion and improving the safety of consumers and staff on inpatient units. The Safewards model includes ten interventions designed to reduce conflict (e.g. physical or verbal aggression, absconding) and restrictive practices (e.g. forced medication, seclusion, restraint)[89]

84 I am part of a team who have been evaluating the implementation of the Safewards intervention in Victoria and we have found that, when Safewards fidelity was high, it has resulted in a reduction in seclusion.[90] We found that one of the challenges is that some wards were prepared to fully implement Safewards, while others were not, and this impacted on how effective it was. This is consistent with, as I mentioned in paragraph 70 there being patches of high use of restrictive practices within some parts of the mental health sector.[91]

85 I recommend that there should be a post-incident review every time a person is subject to seclusion or restraint under the Act. There is not much evidence in Victoria that post-incident reviews, that genuinely include the person involved in the incident and their informal supporters, routinely take place in Victoria's inpatient units despite evidence that these reviews can reduce the use of seclusion and restraint[92]. The post-incident review should not just be the completion of a form, but an opportunity for a conversation with a person and the treating team about how restrictive practices may be prevented in the future. Evidence around post-incident reviews is that they start reducing the amount of

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[88] Fletcher, J., Buchanan-Hagen, S., Brophy, L., Kinner, S. A., & Hamilton, B. (2019). Consumer Perspectives of Safewards Impact in Acute Inpatient Mental Health Wards in Victoria, Australia.

[89] Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. Journal of Psychiatric and Mental Health Nursing, 21(6), 499-508. doi:10.1111/jpm.12129.

[90] Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing*, *26*(5), 461–471.

[91] VMIAC. (2019). *Seclusion report.* Retrieved from: https://www.vmiac.org.au/wp-content/uploads/Seclusion-Report_VMIAC_Vic-mental-health-hospital-services_APRIL_2019_FINAL.pdf

[92] Goulet, M. H., Larue, C., & Lemieux, A. J. (2018). A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting. *Perspect Psychiatric Care*, 54(2), 212-220. doi:10.1111/ppc.12225

restrictive intervention for a specific person and for the mental health service itself. Further, I consider that post-incident reviews would also provide a means of accountability over the use of restraints and seclusion in Victoria and would allow, for example, the Office of Chief Psychiatrist, to have information about incidents of restraint and seclusion; including where they occur and why.

Impact of restrictive practices on workers within mental health services

86 The use of restrictive practices can impact workers within mental health services. I consider that fears about staff safety is a barrier to the sector committing to the removal of seclusion and restraint in Victoria. However, imposing restrictive interventions on a person can also contribute or cause harm to staff. In a study examining staff perceptions of the impact of the Safewards model in Victoria (as referred to in paragraphs 80 and 83 above), staff members reported feeling safer and more connected with consumers after implementing the interventions[93]. The results suggest that the use of restrictive practices may have a negative psychological impact on mental health staff who may have seen restrictive interventions as being counterproductive to assisting a person's improvement in their health. Staff's experience of fear in the face of potential risks requires supportive management and leadership, among many things. In my view, solutions outside of restrictive interventions need to be explored to support the safety of both consumers and staff.

The impact of service leadership, operating models and physical environments on restrictive practices

87 The common themes we found in qualitative findings regarding restrictive practices included:

(a) The need to reduce boredom in wards:

I consider that a real problem, particularly in an inpatient environment, that may contribute to staff perceiving a need to impose restrictive practices, is the result of people being bored and not having meaningful and purposeful things to do when they are in an inpatient unit. This can lead to an increased potential for interpersonal conflict and an urge to leave (or be absent without permission) with the consequence of restrictive practices being imposed. The need to reduce boredom among consumers who are under-occupied was the highest priority recommendation in our study focused on the locking of doors in Queensland's inpatient units, based on rankings by staff, consumers and carers.

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[93] Safewards Impact in Inpatient Mental Health Units in Victoria, Australia: Staff Perspectives. (2019). *Frontiers in Psychiatry*, 10(JULY), 462.

(b) The value of peer support workers:

In our research, peer support has been identified as being vital to ensuring that understanding, empathy and recovery-oriented practice occur in the inpatient setting. This has been a key strategy identified - along with advocacy - to enable elimination or reduction of seclusion and restraint[94].

(c) Problems with inpatient environments:

One other consideration in relation to reducing restraint and seclusion rates in Victoria, is the physical environment of inpatient units and emergency departments and why that setting contributes to higher rates of restrictive practices being imposed. The design of inpatient units may be contributing to high rates of restrictive practices being utilised, as may overcrowding, excess noise and lack of privacy in those units. In a literature review we recently undertook– as yet unpublished - we concluded that improved design of inpatient units, including, for example, reducing custodial features and creating a more homelike environment, had significant potential to reduce the use of restrictive interventions.

Clinical leadership

88 I consider that good leadership and training is the key to influencing the rates of use of restrictive practices within mental health services. Also, it is key for leadership to have zero tolerance for employees trying to interfere with new innovations being implemented to reduce restrictive practices. This is particularly important around the reduction in the use of restrictive practices given they can be highly traumatic and are contrary to recovery and trauma-oriented models of practice. Leaders and managers must have good oversight of every situation where restrictive practices are imposed by their staff members as a form of accountability and to ensure restrictive practices are imposed as a last resort. One way for leadership to impose changes around culture and practices is to also work with the relevant unions and professional associations and to develop mutual understanding and education around the harms associated with the use of restrictive practices in a mental health setting. Including people with lived experience of mental distress and restrictive practices in leadership roles is also likely to support a change in culture.

Workplace culture

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[94] Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J. and McSherry, B. M. (2016) 'Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings', *Australian Health Review* 40(6): 599-604.

89 As summarised by Piers Gooding and colleagues in a recent publication there is considerable potential in the evidence emerging about Safewards, the Six Core Strategies and Open Door Policies in reducing the use of restrictive interventions.[95] For example, in a study examining the effect of the Safewards model, seclusion rates were reduced by 36% in Safewards trial wards, while in comparison wards there was no reduction from baseline seclusion rates[96]. This suggests that workplace characteristics, including staff training, can shape rates of seclusion and restraint. In considering training, issues around rostering and routines are practical considerations in mental health services. For example, staff rostered on night shift must have the same access to training. Working in organisations that are highly risk-averse was described as difficult for staff in both our locked wards study in Queensland and in the Safewards projects. This common problem, of trying to be recovery oriented while also having a high level of tolerance of restrictive interventions and working in very risk averse environments in which consumers were not given much choice and control, created tension and 'mixed messages' for staff.

90 We found that the Safewards interventions did help staff to reduce the degree to which they 'othered' consumers and were more able to see them as people like themselves. Reducing this social distance and enhancing this mutual regard seemed to relate to more sharing of responsibility and collaboration between consumers on the inpatient unit and staff. Safewards can help to facilitate a more recovery-oriented environment because it enhances consumer involvement in their care and treatment, hope and peer support, choice, dignity and respect. These outcomes potentially contributed to the cultural change that is required to reduce restrictive practices[97].

The use of restrictive practices as a last resort

91 The Act currently indicates that restraint and seclusion should be used a last resort. However, the practice around restrictive practices does not seem to match the principles of the Act. If we continue to allow restrictive practice – and perhaps persuasive arguments can be made that there are rare and extreme circumstances when this is necessary - then the Act requires amendment to be clearer around the principles that restraint and seclusion are to be used only as a last resort. It also needs to take into account the harms that continuing to allow restrictive practices – even as a last resort – may generate. These harms are not only to individual consumers, their families and staff but also the culture of

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[95] Gooding, P., McSherry, B., & Roper, C. (2020). Preventing and reducing 'coercion'in mental health services: an international scoping review of English-language studies. *Acta Psychiatrica Scandinavica*.

[96] Fletcher, J., Spittal, M., Brophy, L. et al. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing*, 26, 461–471.

[97] Fletcher, J., Hamilton, B., Kinner, S. and Brophy, L. (2109) 'Safewards impact in inpatient mental health units in Victoria Australia: Staff perspectives', *Frontiers in Psychiatry* 10, doi:10.3389/fpsyt.2019.00462.

services and broader community perceptions. Hence considerable safeguards are required.

Standards, oversight and monitoring of restrictive practices

92 An independent statutory body that oversees and monitors restrictive practices must have power and influence in order to ensure they achieve cooperation from mental health services. However, any independent body must interact with mental health services in a positive and effective way and to promote changes to the sector's use of restrictive practices. The creation of such a body should not also have an unintended effect of requiring the sector to complete more forms and paperwork at the cost of being with and offering treatment, care and support to consumers. As discussed above this may require a return to a statewide OPS or the establishment of a commission with considerable powers to regulate the sector.

Research in relation to restrictive practices

93 I refer to paragraphs 75-76 in relation to the impact of research in also responding to research and its impact on the use of restrictive practices. Various projects I have been involved in, including the Safewards evaluation and the National restraint and seclusion project[98], have been promising in generating research findings that are informing practice change. However, it is commonly concluded that more research is needed, especially to explain the large variations in the use of seclusion and restraint and how to enable and sustain practice change. In my view, we require research that uses a 'mixed methods' approach to understand what the current practices are around restrictive practices, how we support staff and consumers, and how we support staff to shift practice. Research needs to include the principles of co-production and be multidisciplinary and inclusive to ensure that lived experience, clinical, and human rights perspectives are reflected in the research design. Arrangements that could be put in place to support the rapid translation of research into practice could be through embedding research findings into policy change and enabling multiple methods of communicating findings – for example it can be helpful to have plainly written summary documents, staff training events and consumer engagement events, as well as the usual conferences, reports and peer reviewed publications. In our research we commonly include advisory panels – including lived experience advisory panels, clinical and international expert advisors. This ensures that the research remains connected to, and informed by, the broader community of stakeholders and, in turn, those panels can assist with rapid translation. Initiatives such as the Centre for Mental Health Learning and the state-wide DHHS Mental Health

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[98] Kinner, S.A., Harvey, C., Hamilton, B., Brophy, L., Roper, C., McSherry, B. and Young, J.T. (2017) 'Attitudes towards seclusion and restraint in mental health settings: findings from a large, community-based survey of consumers, carers and mental health professionals', *Epidemiology and Psychiatric Sciences* 26(5): 535-44.

Workforce Reference Group also have an important role to play in supporting the rapid translation of research into practice.

WORKFORCE CAPABILITY AND CONFIGURATION

Professional behaviours and practices that underpin multi-disciplinary, recovery-oriented consumer and family-centred care

94 Personal recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness' [99]

95 I have had a focus on training people in recovery-oriented practice and I consider that practice and trauma informed care are fundamental in providing multi-disciplinary, consumer-focused and family-centred care. It is important for the workforce to be trauma informed because we hear stories about people being retraumatised by their experience of being on a compulsory treatment order. For example, for a woman who has experienced sexual abuse in childhood, something that may have been a significant factor in their subsequent experience of mental distress or a diagnosis of mental illness, being forced to comply with an injection symbolically becomes a reminder of the type of abuse they have already experienced. It is also – as previously discussed – incompatible with the aspirations of a recovery oriented approach.

96 According to a recovery-oriented framework, the working relationship between staff and consumers is crucial to the process of recovery. The PULSAR intervention as discussed at paragraphs 41-44 above, developed and supported this relationship by: assisting teams to develop a shared understanding of personal recovery; exploring existing values held by individual workers and the team; developing skills in coaching; and raising the expectations held by consumers that their values, strengths and goals will be prioritised in their relationships with staff members. We involved facilitators with lived experience and a Lived Experience Advisory Panel (LEAP) in the research and the training. I consider that learning from our lived-experience colleagues and their capacity for deep listening is essential in providing care to consumers. The involvement of facilitators with lived experience of mental health issues and recovery in our training challenged conventional practices and assisted in making progress towards an effective recovery-oriented mental health workforce.

97 In her commentary, also published in Lancet Psychiatry, Professor Sally Rogers from the Center for Psychiatric Rehabilitation, Boston University, described the PULSAR study as:

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[99] Anthony W. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosoc Rehab J 1993; 16: 11–23. (p.21)

> *an innovative and ambitious undertaking that offers valuable information for researchers, service providers, policy makers, and individuals in recovery and their families.*

She went on to say:

> *Why do we need large-scale studies focused on recovery for individuals with severe mental illnesses? In most places in the world, psychiatric disorders continue to be associated with enormous personal and social costs, including greater morbidity and mortality than in the general population, lost economic productivity, stigma, discrimination, and poverty. Shifting the focus of mental health treatment and services to a recovery orientation can address these multifaceted problems. (*p.83)[100]

98 Social workers have the potential to be at the forefront of improved uptake of psychosocial interventions, recovery-oriented practice and supported decision making. Encouraging systemic and individual advocacy and supporting empowerment, particularly through enhancing relationships, working alongside peer support workers, and engaging with co-production, provide opportunities for fundamental social work values and principles to be realized in practice. However, social workers have more to offer and need to be recognised for that contribution. Social workers have specialist skills in addressing housing insecurity, poverty, lack of informal support, loneliness and social isolation and insufficient access to health and welfare services. These skills are strongly linked to what consumers frequently identify as their priority needs[101]

New roles, capabilities, training and skills for allied health workforces in mental health

99 In my view, one essential set of capabilities and skills required is for mental health professionals to return to the core conditions of practice and be able to listen to people and be compassionate, kind and empathetic. Many people who access mental health services complain that they are not heard and there is a lack of focus on developing good working relationships. A re-focus on advanced interpersonal skills and active listening for allied health professionals and other clinicians are essential in my view[102]. These advanced interpersonal skills are particularly required with people on compulsory treatment orders. Therapeutic relationship building will assist them in progressing in their treatment so they can be removed from a compulsory treatment order. Further to this, we should not have a situation where we leave this use of soft skills, and focus on personal

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[100] Rogers, E. S. (2019). Recovery-oriented practices need innovative research. *The Lancet Psychiatry*, 6(2), 82-83.

[101] Hayes, L, Brophy, L, Harvey, C. (2016) Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery. Melbourne: The Centre for Mental Health, Melbourne School of Population Health & Mind Australia.

[102] Hooff, S., & Goossensen, A. (2014). Review of how to increase quality of care during coercive admission? A review of literature. *Scandinavian Journal of Caring Sciences*, 28(3), 425–434.

recovery and trauma approaches, to peer support colleagues. I consider that people on treatment orders need access to peer support but that the rest of the mental health workforce should also be encouraged to learn from their peer support colleagues and for peer support colleagues to learn from one another. The workforce needs to have mutually respectful roles.

100 There should be consideration of specialist teams for people on compulsory treatment orders both as inpatients and on CTOs. There is evidence about the unexpected length of CTOs, suggesting difficulty in getting people removed from these orders. Specialist clinicians may assist with the cessation of compulsory treatment for some people. A possible new role that might be considered in Victoria is the approved mental health practitioner (**AMHP**) role that has been created in the United Kingdom. Currently, Victoria does not have an equivalent role. AMHPs are specialised, accredited and trained mental health providers who also have an acute understanding of the mental health legislation and its implementation. An AMHP is required to be involved if an application is being considered for someone to be compulsorily treated. The AMHP works with medical practitioners in deciding whether a compulsory order is necessary. The AMHP brings a social perspective and is expected to be knowledgeable, analytical and innovative and able to determine if all other less restrictive alternatives have been exhausted[103]. AMHPs need to also negotiate the tensions around decision-making related to management and assessment of risk including the ethical and human rights implications, the poor predictive ability of risk assessment and the fear of the consequences of not being risk averse. For an AMHP role to be successful it must have statutory powers, be supported by the current system and have the appropriate workforce in place. However, in creating specialist roles and teams that respond solely to compulsory treatment, care must be taken to ensure this innovation does not disrupt continuity of care, which as I have discussed in paragraph 59-60 may contribute to involuntary treatment.

101 In relation to pre-service training and accreditation, it is important that accreditation standards are informed by the latest evidence, incorporate consumer and carer perspectives and the realities of day to day practice. Often preparation for mental health practice is expected to focus on diagnosis, assessment and treatment. However, my responses above identify how important it is to also prepare students for the very big challenges ahead of them in working in and around mental health services. I would summarise these as follows:

(a) Addressing the physical health needs of consumers of mental health services;

(b) Understanding psychosocial disability and addressing functional impairment;

(c) Respecting human rights and reducing restrictive interventions and coercion;

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[103] Stone, K. (2019). Advanced roles for social work: The approved mental health professional. Compass 2019, 2019.

(d) Enabling legal capacity and supported decision making;

(e) Addressing stigma and discrimination;

(f) Engaging with the impact of social exclusion, housing insecurity and poverty;

(g) Responding to trauma – focusing on “what happened to you?” rather than “what’s wrong with you?”[104];

(h) Valuing continuity of care and therapeutic relationships;

(i) Ensuring access to evidence based psychosocial interventions and supports;

(j) Personalisation, respecting choice and control and working with the NDIS; and

(k) Co-production and power sharing with people with lived experience and engaging in the development of new and innovative models of care while also supporting peer led services such as recovery colleges and crisis houses.

Enhancing workforce capabilities and skills to reduce compulsory treatment and restrictive practices

102 It appears that system change requires improved and consistent recognition of the human rights issues, trauma, and harm associated with coercive interventions. Facing up to the very real issue of ongoing stigma and discrimination among staff, as well as staff's experience of fear in the face of potential risks requires supportive management and leadership, among many things

103 I consider that further education also needs to be incorporated for those that work with people on compulsory orders. There has been an uptake in education and training for recovery orientated practice and trauma informed practice, but there is not specific training about working with people on compulsory orders in Victoria. In my view, the current expectation that staff in secondary care mental health services will frequently be required to work with people on compulsory orders is not more broadly understood. This needs to be more clearly acknowledged and addressed in policy and practice guidelines. This could be an essential pre-cursor to further training being developed and thus offering more preparation for working with people on compulsory treatment orders within the principles of the Act. Policy and practice guidance, and related training, can sustain a focus on how to achieve less restrictive care. These developments require input from people with lived experience expertise.

104 I have not seen priority being given to training staff involved in mental health services about how to work with people under compulsory treatment orders. In my view since the 1990s, we have neglected to properly train all staff, including medically trained staff and

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[104] Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 0022167818793289.

psychiatrists, who are sometimes unaware and unprepared for more than 25% of their clients being subject to compulsory orders. This includes a lack of training about how mental health staff and clinicians appear before the Tribunal and being well-prepared for it. As such, we need to strengthen workforce capabilities and skills specifically in relation to persons who are subject to compulsory treatment orders. We also need to educate the workforce about providing intensive support ahead of a person deteriorating to the degree that compulsory treatment is required. Peer support workers need to be included in this training to enable an interdisciplinary perspective. Additionally, I consider that more experienced staff, particular in continuing care teams, should be involved in the treatment of people on involuntary treatment orders rather than a reliance on a junior workforce to provide this care if additional training is not provided.

105 When we evaluated Safewards, consumers told us that some staff just didn't seem to have the ability to carry out all components of the intervention. It appeared that full time staff were able to adopt the intervention more readily than part time, casual and night staff. This may relate to their access to training, supervision and support. We concluded that:

> *improving staff culture was strongly linked to education and training, but also to steps such as 'weeding out' staff who appeared to lack skills and compassion and introducing more consumer feedback and involvement in services was likely to be helpful in reducing restraint and seclusion. Greater recognition of staff skills to calm and defuse situations was seen as a positive contribution to culture change* [105].

Attached to this statement and marked LB-1 is a copy of my curriculum vitae.

sign here ► Lisa Brophy

print name Lisa Brophy

date 29/04/2020

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[105] Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J. and McSherry, B. M. (2016) 'Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings', Australian Health Review 40(6): 599-604

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LB-1

This is the attachment marked LB-1referred to in the witness statement of Lisa Brophy dated 29 April 2020.

2020 Curriculum Vitae – Lisa Brophy

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SUMMARY

My current position is Professor and Discipline Lead in Social Work and Social Policy at La Trobe University. I am also an honorary principal research fellow in the Centre for Mental Health in the Melbourne School of Population and Global Health at the University of Melbourne, leading the Recovery and Social Justice Unit. I was recruited to the position of Director of Research at Mind Australia (Mind) in January 2011 in a position that was conducted in partnership with the Centre for Mental Health. I was employed full time by the University in an innovative in-reach and capacity building position. My research focus has been on people experiencing mental ill illness and psychosocial disability and their recovery, social inclusion and human rights. These research interests will remain in my new position that also requires leadership and service to the University and involvement in teaching Social Work students from undergraduate to PhD.

I have a professional background in Social Work and a career long commitment to the mental health field of practice dating back to 1985. I graduated with a Master's in Policy and Law from La Trobe University in 1995 and a PhD from The University of Melbourne in 2009. My PhD focused on good practice with people on Community Treatment Orders and I have been involved in local and international collaborations regarding mental health law and its implications for policy, law reform and direct practice. I was a member of the expert advisory group that reviewed the Victorian Mental Health Act, 1986. I am a current sessional community member of the Victorian Mental Health Tribunal and I was reappointed in April 2018.

The Centre for Mental Health has considerable expertise in relation to mental health research and my position led me to be involved in many research activities including receiving competitive funding grants. My position also included leadership activities at the University including being a member of the Melbourne School of Population Health's Human Ethics Advisory Group for 7 years. In 2016 I participated in the University's Academic Women in Leadership program and in 2018 participated in the University of Melbourne's Research Mentors Program. The aim of this elite Program was to provide outstanding research leaders in the University with the ideas, concepts, and tools to become more knowledgeable and effective mentors of their research staff and students

My career has included a great depth of experience in Social Work practice and leadership and many roles in Schools of Social Work including student placement liaison person, lecturer, sessional tutor and course coordinator. My background in developing and teaching law, ethics and human rights subjects at La Trobe University, The University of Melbourne, and RMIT has led to ongoing collaborations with colleagues in schools of social work in relation to guest lectures, higher degree student supervision, mentoring, and supporting research initiatives.

For 8 years I was in a research only position that has fostered strong interdisciplinary partnerships, working in collaborative research teams with academics from a range of disciplines and universities, across Australia and internationally. Our teams have also included people with lived experience and partners organisations. I have therefore had the opportunity to be involved in research and evaluation activities that are highly participatory and contribute to making a difference for people with mental health illness and psychosocial disability.

TERTIARY EDUCATION

2001 - 2009	PhD, The University of Melbourne School of Social Work
1989-1995	Masters in Policy and Law La Trobe University Qualified for admission to Postgraduate Diploma, 1991 Converted to Masters in Policy and Law and completed in 1995
1983-1984	Bachelor of Social Work La Trobe University
1980-1982	Bachelor of Behavioural Science La Trobe University

EMPLOYMENT HISTORY (last 20 years):

Present Positions

2018 - Aug to Dec (.4) Jan 2019 – (.9)	Professor and Discipline Lead in Social Work and Social Policy at La Trobe University
2016- Aug 2018 (fulltime) Aug – Dec 2018 (.6) Jan 2019 – (.1)	Associate Professor and head of the Recovery and Social Justice Unit. - The Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne and Principal Research Fellow, Mind Australia (Mind).
2013 -	Community Member of Victoria's Mental Health Review Board and, post 2014, the Mental Health Tribunal (reappointed by the Minister for 5 years in April 2018).

Previous Positions

2011 - 2016	Senior Research Fellow, The Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne and Director of Research, Mind Australia (Mind)
2014 – 2015	Member of the AASW National Ethics Panel
2009 - 2011	NorthWestern Mental Health Social Work Academic Educator (Contract position- initially at .3 Jan 2009 to June 2010 then .5 June 2009 to 2012).
2008 - 2013	Community Member of Victoria's Mental Health Review Board, August 2008
2008 – 2011	Expert Advisory Group for the review of the Victorian Mental Health Act (1986).
2008 -	Appointed as a member of the Australian Association of Social Workers national ethics pool.
2007 - 2009	Multiple and Complex Needs Panel – Community member.
2009 – 2011	The University of Melbourne, School of Social Work (Casual Work)
2008 – 2009	RMIT, School of Social Work (Casual Work)
2007	The University of Melbourne, School of Social Work (Fixed term. Contract position Level B 0.8)
2006	The University of Melbourne, School of Social Work (Casual Work)

2004	Department of Human Services, Mental Health Branch. Senior Project Officer (Part time Secondment) (July to December 2004)
2002 – 2008	La Trobe University, School of Social Work and Social Policy (Casual Work)
2002 – 2010	Chief Social Worker, North West Area Mental Health Service Permanent .5 (Job Share)

Responsibilities in previous roles:

I graduated from La Trobe University with a Bachelor of Social Work in 1985 and my practice experience as a social worker has been concentrated in the field of mental health, particularly community mental health, which has enabled the development of direct service skills in working with individuals, families and groups and undertaking case management. I have had numerous roles in the mental health field of practice, from an entry level position in the community, through to a Chief Social Work position. As a senior social worker I was involved in the recruitment, supervision and representation of Social Work staff in the mental health field. I was involved in social work student placement supervision during my years working as both a social worker and as an academic and I have offered private supervision to social workers in the field. I have worked part time in the Schools of Social Work at La Trobe University, The University of Melbourne and RMIT. I have particular expertise in co-ordinating and teaching subjects on law and ethics in social work. I have also been involved in teaching direct practice skills. As a Community member of the Victorian Department of Human Services Multiple and Complex Needs Panel I was involved in deciding on, and reviewing, the individual care plans of people with multiple and complex needs on a multidisciplinary panel in Victoria. In 2008 I was appointed to the AASW ethics pool, requiring sessional participation in hearing panels, as required, in relation to complaints regarding breaches of the code of ethics by AASW members. In 2009 I achieved two ministerial appointments, one to the Expert Advisory Group for the review of The Mental Health Act, 1986 providing expert advice to the Legislative Review Team regarding the current review of the Act, and the second as a Community Member of the Mental Health Review Board of Victoria. In 2010 I was invited by the Victorian Government Department of Health to be a member of reference group of the Youth Residential Rehabilitation and Adult Residential Rehabilitation Program Review. All of these appointments reflect recognition of my experience and contribution to the social work and the mental health field.

Current memberships of Commonwealth and/or Victorian Government public entities, statutory bodies and/or advisory committees:

- Member of the **Expert Taskforce on Mental Health - Workforce reference group**, Health and Human Services. One of 11 members determined by the Secretary to the department in consultation with the Minister for Mental Health – 2016 -
- Membership of the **Victorian Chief Psychiatrist Restrictive Interventions Committee (2016 -).** I was invited to join this committee in 2016
- Membership of the **Supported Decision Making Subcommittee, Royal Australian and New Zealand College of** Psychiatrists (2016 -)
- Membership of the **Operational Access Review for Psychosocial Disability (NDIA) (2015 -)**
- Editorial Advisor - **Australian Social Work**
- Member of the Editorial Board - **International Journal of Mental Health Systems**
- Associate editor - **BMC Psychiatry**
- **RECOLLECT** – Recovery Colleges UK research - International Advisory Committee
- **Supported Decision Making Project** – Northern Ireland - International Advisory Committee

Current memberships of non-government bodies:

- **Mental Health Clinical Network - Information sharing in generating health outcomes (INSIGHT) subcommittee** (2019 -)
- Australian Association of Social Workers (AASW) **Mental Health National Advisory Panel** (2019 -)
- **Membership of World Association of Psychosocial Rehabilitation (WAPR-**Australia) – Treasurer of the Interim Committee (chaired by Professor Carol Harvey) (2017 -)
- **Ending loneliness together - Scientific Advisory Committee member** (2018 -)
- **Recovery Colleges International Community of Practice** (2015 -).
- **Recovery Colleges Characterisation and Testing (RECOLLECT)** International Advisory Board (2016 -)
- Member of the **Australian Association of Social Workers** (AASW)
- Member of the **National Tertiary Education Union**

Other examples recent academic activities:

- Member of the Local Advisory Committee supporting the **World Psychiatric Association's Thematic Congress,** Innovation in Psychiatry: Effective Interventions for Health and Society in Melbourne Australia, 25-28 February 2018.
- **Joint Conference on Social Work, Education, and Social Development 2018** – Abstract review

Research Training:

- Women's Academic Promotion Support Program La Trobe University 2019/2020
- University of Melbourne's Research Mentors Program, an annual program that targets research leaders across the university in 2018.
- Academic Women in Leadership Program at the University of Melbourne in 2016

REFEREED JOURNAL ARTICLES

1. Young JT, Borschmann R, Heffernan E, Spittal MJ, Brophy L, Ogloff JRP, Moran P, Armstrong G, Preen DB, Kinner SA. Contact with mental health services after acute care for self-harm among adults released from prison: A prospective data linkage study. Suicide and Life-Threatening Behavior. 2020; Epub ahead of print. DOI:10.1111/sltb.12639

2. Devine, A., Vaughan, C., Kavanagh, A., Dickinson, H., Byars, S., Dimov, S., . . . Brophy, L. (2020). 'I'm proud of how far I've come. I'm just ready to work': mental health recovery narratives within the context of Australia's Disability Employment Services. *BMC Public Health*, *20*(1), 18 pages. doi:10.1186/s12889-020-8452-z
3. Cox, D., Cleak, H., Bhathal, A., & Brophy, L. (2020). Theoretical frameworks in social work education: a scoping review. *Social Work Education*. doi:10.1080/02615479.2020.1745172
4. *Green, R., Mitchell, P. F., Lee, K., Svensson, E., Toh, J. -W., Barentsen, C., . . . Brophy, L. (2019). Key features of an innovative sub-acute residential service for young people experiencing mental ill health. *BMC PSYCHIATRY*, *19*(1), 13 pages. doi:10.1186/s12888-019-2303-4
5. ^Edan, V., Brophy, L., Weller, P. J., Fossey, E., & Meadows, G. (2019). The experience of the use of Community Treatment Orders following recovery-oriented practice training. *International Journal of Law and Psychiatry*, *64*, 178-183. doi:10.1016/j.ijlp.2019.04.001
6. *Fletcher, J., Hamilton, B., Kinner, S. A., & Brophy, L. (2019). Safewards Impact in Inpatient Mental Health Units in Victoria, Australia: Staff Perspectives. *Frontiers in Psychiatry*, *10*, 10 pages. doi:10.3389/fpsyt.2019.00462
7. Meadows, G., Brophy, L., Shawyer, F., Enticott, J. C., Fossey, E., Thornton, C. D., . . . Slade, M. (2019). REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: A stepped-wedge cluster randomised controlled trial. *Lancet Psychiatry*, *6*(2), 103-114. doi:10.1016/S2215-0366(18)30429-2
8. ^Cocks, N., Brophy, L., Segan, C., Stratford, A., Jones, S., & Castle, D. (2019). Psychosocial Factors Affecting Smoking Cessation Among People Living With Schizophrenia: A Lived Experience Lens. *Frontiers in Psychiatry*, *10*, 8 pages. doi:10.3389/fpsyt.2019.00565
9. Sweeney, R., Moodie, M., Baker, A. L., Borland, R., Castle, D., Segan, C., . . . McCarter, K. (2019). Protocol for an economic evaluation of the Quitlink randomized controlled trial for accessible smoking cessation support for people with severe mental illness. *Frontiers in Psychiatry*, *10*, 10 pages. doi:10.3389/fpsyt.2019.00618
10. Harvey, C., Brophy, L., Tibble, H., Killaspy, H., Spittal, M. J., Hamilton, B., . . . Fletcher, J. (2019). Prevention and recovery care services in Australia: Developing a state-wide typology of a subacute residential mental health service model. *Frontiers in Psychiatry*, *10*, 10 pages. doi:10.3389/fpsyt.2019.00383
11. Devine, A., Dickinson, H., Brophy, L., Kavanagh, A., & Vaughan, C. (2019). 'I don't think they trust the choices I will make.' - Narrative analysis of choice and control for people with psychosocial disability within reform of the Australian Disability Employment Services program. *Public Management Review*, 21 pages. doi:10.1080/14719037.2019.1648700
12. Fletcher, J., Buchanan-Hagen, S., Brophy, L., Kinner, S. A., & Hamilton, B. (2019). Consumer Perspectives of Safewards Impact in Acute Inpatient Mental Health Wards in Victoria, Australia. *Frontiers in Psychiatry*, *10*, 11 pages. doi:10.3389/fpsyt.2019.00461

13. *Brophy, L., Kokanovic, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community Treatment Orders and Supported Decision-Making. *Frontiers in Psychiatry*, *10*, 12 pages. doi:10.3389/fpsyt.2019.00414

14. Young, J. T., Borschmann, R., Preen, D. B., Spittal, M. J., Brophy, L., Wang, E. A., . . . Kinner, S. A. (2019). Age-specific incidence of injury-related hospital contact after release from prison: A prospective data-linkage study. *Injury Prevention*, 11 pages. doi:10.1136/injuryprev-2018-043092

15. Baker, A. L., Borland, R., Bonevski, B., Segan, C., Turner, A., Brophy, L., . . . Castle, D. (2019). "Quitlink" — A Randomized Controlled Trial of Peer Worker Facilitated Quitline Support for Smokers Receiving Mental Health Services: Study Protocol. *Frontiers in Psychiatry*, *10*, 15 pages. doi:10.3389/fpsyt.2019.00124

16. ^Fletcher, J., Brophy, L., Killaspy, H., Ennals, P., Hamilton, B., Collister, L., . . . Harvey, C. (2019). Prevention and Recovery Care Services in Australia: Describing the Role and Function of Sub-Acute Recovery-Based Residential Mental Health Services in Victoria. *FRONTIERS IN PSYCHIATRY*, *10*, 11 pages. doi:10.3389/fpsyt.2019.00735

17. Maker, Y., Paterson, A., Arstein-Kerslake, A., McSherry, B., & **Brophy, L.** (2018). From safety nets to support networks: beyond 'vulnerability'in protection for consumers with cognitive disabilities. Journal of Law in Context, 8, 1.
18. Maker, Y., Arstein-Kerslake, A., McSherry, B., Paterson, J. M., & **Brophy, L**. (2018). Ensuring equality for persons with cognitive disabilities in consumer contracting: An international human rights law perspective. Melbourne Journal of International Law, 19, 178.
19. *Fletcher, J., Hamilton, B., Kinner, S., Sutherland, G., King, K., Tellez, J., . . . **Brophy, L.** (2018). Key stakeholder views: Least restrictive environments in the context of the Queensland locked door policy. International Journal of Mental Health Nursing Vol. 27 (pp. 13).
20. ^Faithfull, S., **Brophy, L.,** Pennell, K., & Simmons, M. B. (2018). Barriers and enablers to meaningful youth participation in mental health research: qualitative interviews with youth mental health researchers. Journal of Mental Health.
21. Kokanović, R., **Brophy, L**., McSherry, B., Flore, J., Moeller-Saxone, K., & Herrman, H. (2018). Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners. Australian & New Zealand Journal of Psychiatry, 0004867418784177.
22. *Hall, T., Jordan, H.L., Reifels, L., Belmore, S., Hardy, D., Thompson, H. and **Brophy, L**., 2018. A Process and Intermediate Outcomes Evaluation of an Australian Recovery College. Journal of Recovery in Mental Health, 1(3), pp.7-20.
23. Campbell, J., **Brophy, L**., Davidson, G., & O'Brien, A. M. (2018) Legal capacity and the mental health social worker role: an international comparison, *Journal of Social Work Practice*, 32(2), 139-152
24. Kinchin, I., Heyeres, M., Whatley, E., Brophy, L., Jago, J., Wintzloff, T., ... & Tsey, K. (2018). Evaluation of a Residential Mental Health Recovery Service in North Queensland. *Frontiers in Public Health*, 6, 123.
25. Young, J.T., Heffernan, E., Borschmann, R., Ogloff, J.R., Spittal, M.J., Kouyoumdjian, F.G., Preen, D.B., Butler, A., **Brophy, L**., Crilly, J. and Kinner, S.A.(2018). Dual diagnosis of mental illness and substance use disorder and injury in adults recently released from prison: a prospective cohort study. *The Lancet Public Health*, (first online)
26. Knight, F., Kokanović, R., Ridge, D., **Brophy, L**., Hill, N., Johnston-Ataata, K., & Herrman, H. (2018). Supported Decision-Making: The Expectations Held by People With Experience of Mental Illness. *Qualitative Health Research.* (first online)

27. Hayes, L**.,** **Brophy, L**., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry.* (first online)
28. ***Brophy, L**., Edan, V., Gooding, P., McSherry, B., Burkett, T., Carey, S., . . . Weller, P. (2018). Community treatment orders: towards a new research agenda. *Australasian Psychiatry.* (first online)
29. Fletcher, J., Spittal, M., **Brophy, L**., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International journal of mental health nursing*, 26(5), 461-471.
30. Spittal, M. J., Shand, F., Christensen, H., **Brophy, L**., & Pirkis, J. (2017). Community mental health care after self-harm: A retrospective cohort study. *Australian and New Zealand Journal of Psychiatry*, *51*(7), 727-735.
31. ***Brophy, L**. (2017). Responding to the Needs of Voice Hearers and Expanding Access to Evidence-based and Innovative Psychosocial Interventions Commentary on "Are Hearing Voices Networks Compatible with Cognitive Behavioural Therapy for Psychosis?" (Kay, Kendall, & Dark, 2017). *Australian Social Work*, *70*(4), 508-510.
32. Kinner, S. A., Harvey, C., Hamilton, B., **Brophy, L**., Roper, C., McSherry, B., & Young, J. T. (2017). Attitudes towards seclusion and restraint in mental health settings: findings from a large, community-based survey of consumers, carers and mental health professionals. *Epidemiology and Psychiatric Sciences*, *26*(5), 535-544.
33. Shawyer, F., Enticott, J. C., **Brophy, L.,** Bruxner, A., Fossey, E., Inder, B., . . . Meadows, G. N. (2017). The PULSAR Specialist Care protocol: a stepped-wedge cluster randomized control trial of a training intervention for community mental health teams in recovery-oriented practice. *BMC Psychiatry*, *17*, 19 pages.
34. Harvey, C., Farhall, J., Parsons, S., Lewis, J., **Brophy, L**., Moeller-Saxone, K., . . . Siskind, D. (2017). Rehabilitation for Australians living with complex psychoses: epidemiological data on how the current gap between evidence and implementation may be bridged. *Australian and New Zealand Journal of Psychiatry*, *51*, 71-72.
35. Brady, N. S., Spittal, M. J., **Brophy, L**. M., & Harvey, C. A. (2017). Patients' experiences of restrictive interventions in Australia: Findings from the 2010 Australian survey of psychosis. *Psychiatric Services*, *68*(9), 966-969.
36. Maker, Y., McSherry, B., **Brophy, L**., Paterson, J., & Arstein-Kerslake, A. (2017). Supporting People with Decision-Making Impairments: Choice, Control and Consumer Transactions. *Journal of Law and Medicine*, 756-762.
37. Young, J. T., Cumming, C., van Dooren, K., Lennox, N. G., Alati, R., Spittal, M. J., . . .**Brophy,L**… Kinner, S. A. (2017). Intellectual disability and patient activation after release from prison: a prospective cohort study. *Journal of Intellectual Disability Research*, *61*(10), 939-956.
38. Enticott, J. C., Shawyer, F., **Brophy, L**., Russell, G., Fossey, E., Inder, B., . . . Meadows, G. (2016). The PULSAR primary care protocol: a stepped-wedge cluster randomized controlled trial to test a training intervention for general practitioners in recovery-oriented practice to optimize personal recovery in adult patients. *BMC Psychiatry*, *16*, 16 pages.
39. Thomas, N., Farhall, J., Foley, F., Rossell, S. L., Castle, D., Ladd, E., ... **Brophy, L.** & Frankish, R. (2016). Randomised controlled trial of a digitally assisted low intensity intervention to promote personal recovery in persisting psychosis: SMART-Therapy study protocol. *BMC psychiatry*, 16(1), 312.
40. Sellars, M., Fullam, R., O'Leary, C., Mountjoy, R., Mawren, D., Weller, P., **Brophy, L,**… & Silvester, W. (2016). Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette. *Psychiatry, Psychology and Law*, 1-13.
41. Harvey, C., **Brophy, L**., Parsons, S., Moeller-Saxone, K., Grigg, M., & Siskind, D. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry*, Vol. 50(6) 534– 547

42. ***Brophy, L**. M., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (2016). Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups. *International journal of mental health systems*, 10(6) 1-10.
43. Davidson, G., **Brophy, L.,** & Campbell, J. (2016). Risk, Recovery and Capacity: Competing or Complementary Approaches to Mental Health Social Work. *Australian Social Work*, 69 (2), 158-168.
44. ***Brophy, L**., Roper, C., Hamilton, B., Tellez, J. J., & McSherry, B. (2016). Consumers and their supporters Perspectives on Barriers and Strategies to Reducing Seclusion and Restraint in Mental Health Settings. *Australian Health Review*. 40(6), 599-604.
45. O'Donoghue, B., **Brophy, L.,** Owens, N., Rasic, M., McCullough, B., Huang, B., Vine, R. & McKenna, B. (2016) Rate of community treatment orders and readmission orders following reconfiguration of community mental health services. *Australasian Psychiatry*. 1039856216629841 Published online before print February 5, 2016
46. ***Brophy, L**., Bruxner, A., Wilson, E., Cocks, N., & Stylianou, M. (2015). How Social Work Can Contribute in the Shift to Personalised, Recovery-Oriented Psycho-Social Disability Support Services. *British Journal of Social Work*, 45(suppl 1), i98-i116.
47. Roper, C., McSherry, B. & **Brophy, L**. (2015) Defining seclusion and restraint: legal and policy definitions versus consumer and carer perspectives. *Journal of Law and Medicine*, 23, 297-302.
48. ^Stratford, A., **Brophy, L**., Castle, D., Harvey, C., Robertson, J., Corlett, P., ... & Everall, I. (2015). Embedding a recovery orientation into neuroscience research: Involving people with a lived experience in research activity. *Psychiatric Quarterly*, 1-14.
49. Davidson, G., **Brophy, L**., Campbell, J., Farrell, S. J., Gooding, P., & O'Brien, A. M. (2015). An international comparison of legal frameworks for supported and substitute decision-making in mental health services. *International journal of law and psychiatry*. Published online before print 28 August 2015
50. Stratford, A., Kusuma, N., Goding, M., Paroissien, D., **Brophy, L**., Damayanti, Y. R., . . . Ng, C. (2014). Introducing recovery-oriented practice in Indonesia: the Sukabumi project – an innovative mental health programme. *Asia Pacific Journal of Social Work & Development*, 24(1/2), 71-81.
51. Petrakis, M., **Brophy, L**., Lewis, J., Stylianou, M., Scott, M., Cocks, N., . . . Halloran, K. (2014). Consumer measures and research co-production: a pilot study evaluating the recovery orientation of a mental health program collaboration. *Asia Pacific Journal of Social Work & Development*, 24(1/2), 94-108.
52. ***Brophy, L.,** Hodges, C., Halloran, K., Grigg, M., & Swift, M. (2014). Impact of care coordination on Australia's mental health service delivery system. *Australian Health Review*, 38(4), 396-400.
53. ^Stratford, A., **Brophy, L**., Beaton, T., & Castle, D. (2013). Recovery, medication and shared responsibility in mental health care. *Australasian Psychiatry*, 21(6), 550-553.
54. Owens, N., & **Brophy, L**. (2013). Revocation of Community Treatment Orders in a mental health service network. *Australasian Psychiatry*, 21(1), 46-50.
55. ***Brophy, L.,** & McDermott, F. (2012). Using Social Work Theory and Values to Investigate the Implementation of Community Treatment Orders. *Australian Social Work*, 66(1), 72-85.
56. ^Stratford, A., & **Brophy, L**., & Castle, D. (2012). Integrating recovery-oriented practice into psychiatric registrar training. *Australasian Psychiatry*, 20(6), 524-526.
57. Harvey, C. & **Brophy, L**. (2011) Social isolation in people with mental illness. *Medicine Today*, 12(10), 73-78 (republished as Harvey, C. and Brophy, L. (2013) Social isolation in people with mental illness. *Modern medicine* (Middle East). July, 30, 34-38)
58. ***Brophy, L,** Reece, J. and McDermott, F. (2006) A cluster analysis of people on community treatment orders in Victoria, Australia. *International Journal of Law and Psychiatry*. 29, 469-481
59. Campbell, J., **Brophy, L.,** Healy, B., & O'Brien, A. M. (2006). International perspectives on the use of community treatment orders: Implications for mental health social workers. *British Journal of Social Work*, 36, 1101 - 1118.
60. ***Brophy, L**., & Ring, D (2004) The efficacy of involuntary treatment in the community: Consumer and service provider perspectives *Social Work in Health Care*. Vol 2 (2/3), 157 – 174.

61. ***Brophy, L**., Campbell, J., & Healy, B. (2003). Dilemmas in the case manager's role: Implementing involuntary treatment in the community. *Psychiatry, psychology and the law*, 10(1), 154-163.
62. ***Brophy, L**. and McDermott, F. (2003) What's driving involuntary treatment in the community? The social, policy, legal and ethical context. *Australasian Psychiatry* Vol 11, S83- S89.
63. Ryan, M., Cleak, H., **Brophy, L.** and Furlong, M. (2000) An Exploratory Study of the Relationship of Admission Variables and Performance in the Field Education Program in an Australian B.S.W. Course. Advances in Social Work and Welfare Education, 3(1), 117–135.

BOOK CHAPTERS

1. **Brophy, L**. (2019). Legal Provisions, Advocacy and Empowerment. In R. Ow, & A. Poon (Eds.), Mental health and social work (pp. 1-20). Singapore: Springer Nature Singapore Pte Ltd. Retrieved from https://doi.org/10.1007/978-981-13-0440-8_18-1

2. Campbell, J., **Brophy, L.,** Davidson, G., & O'Brien, A. (2019). Legal capacity and the mental health social worker role: an international comparison. In B. Taylor, & A. Whittaker (Eds.), *Professional Judgement and Decision Making in Social Work Current Issues* (pp. tbc pages). Abingdon: Routledge.

3. **Brophy, L**., Healy, B and Maylea, C. (2018) Mental health law and its implications for social work practice, (pp. 277-298) in Rice, S, Day,A and Briskman, L. *Social Work in the Shadow of the Law*, 5th Edition. The Federation Press, Sydney.
4. Brophy, L., Ryan, C. and Weller, P. (2018) Community treatment orders: The evidence and the ethical implications (Chapter 2) in Spivakovsky,C., Seear, K., and Carter, A. Critical Perspectives on Coercive Interventions. Routledge, NY.
5. **Brophy, L** & Healy, B. (2014) Mental health: Mental health law and its implications for social work practice, (Chapter 15) in Rice, S and Day, *Social Work in the Shadow of the Law*, 4th Edition. The Federation Press, Sydney.
6. Fossey, E., **Brophy, L**., Grigg, M., Hamann, J., Hamilton, B., Harvey, C., Minas, H., Thorburn, K. & Watson, S. (2012) Case Management (Chapter 14), in Meadows, G., Farhall, J., Fossey, E., Grigg, M., McDermott, F. and Singh, B. *Mental Health in Australia: Collaborative Community Practice*. Third Edition. Melbourne: Oxford University Press.
7. Buckley, L., Cocks, N., Scott, M., Stylianou, M., **Brophy, L.,** Lewis, J., Halloran, K., Petrakis, M. (2012) Are we recovery orientated? An Australian encounter of learning from people with lived experience. (Chapter 9), in Goodson, L. & Phillimore, J. *Community research for community participation: from theory to method*. Bristol: Policy Press.
8. **Brophy, L.,** & Healy, B. (2009). Law, psychiatry and social work. In P. Swain & S. Rice (Eds.), *In the shadow of the law*. Sydney: The Federation Press.(3rd Edition)
9. Campbell, J., Healy, B., & **Brophy, L**. (2006). Mental health policy, law and risk: Finding a balance between state paternalism and citizenship rights for people with mental health problems. In L. Sapouna & P. Herrmann (Eds.), Knowledge in Mental Health (pp. 25 - 38). New York: Nova Science Publishers, Inc.

REFEREED CONFERENCE PAPERS

1. Doroud, N., Fossey, E., Fortune, T., Brophy, L., & Mountford, L. (2019). Co-producing recovering: Recovery College course ideas based on findings from a participatory Photovoice study with people experiencing mental health issues.. In *The Mental Health Services (TheMHS) Conference 2018.*

2. Hall, T., **Brophy, L**., Jordan, H., Hardy, D., Belmore, S., Scott, A., & Thompson, H. (2017). Co-producing the journey to recovery: The Mind Recovery College. In TheMHS Conference 2016 –

People: authenticity starts in the heart. Auckland, New Zealand: The Mental Health Service Learning Network.

3. Tzougravou, S., Jones, S., Brophy, L., & Moore, G. (2017). Out doors optimal health program: promoting wellbeing. In M. Cassaniti, S. Robertson, L. Dunbar, F. Orr, M. Everett, L. Prowse, . . . D. Christensen (Eds.), TheMHS conference (pp. 1-10). Auckland: TheMHS Conference.
4. McKinlay, A., Segan, C. & **Brophy, L**. (2015) Evaluation of the impact of the release of Mind's Smoke Free Environment Policy, in Kellehear, K, Lane, A, Cassaniti, M, Tooth, B, Chapman, C, Robertson, S, Peters, J, Prowse, L, Farhall, J, Piscitelli, A, Brophy, L, Astbury, R, (2015) What we share makes us strong, Contemporary TheMHS in Mental Health Services, Perth Conference Proceedings 2014, TheMHS Conference, Perth, Western Australia.
5. **Brophy,L**., O'Leary, C., Mountjoy, R., Silvester,W., Cocks, N., Jayakody, E., Pepper, S., Swift, M & Pollack, S. (2015) Implementing Advance Statements in the Victorian Mental Health Sector, in Kellehear, K, et al, (2015) What we share makes us strong, Contemporary TheMHS in Mental Health Services, Perth Conference Proceedings 2014, Perth, Western Australia.
6. **Brophy, L** (2014) Outcome Measurement in Mind Australia: Symposium – Measuring Outcomes in CMOS/NGOS in, Robertson, S, Chapman, C, Kellehear, K, Everett, M, Lane, A, Cassaniti, M, Peters, J, Prowse, L, Hilton, M, Farhall, J, Grigg, M, Forging the Future, Contemporary TheMHS in Mental Health Services, Melbourne Conference Proceedings 2013, Melbourne, Victoria, 63 – 68
7. Lewis, J., **Brophy, L**., Petrakis, M., Halloran,K., Stylianou, M., Scott, M., Cocks, N., Buckley, L. & Hamann, J. (2014) How a Partnership Approach Between a Clinical Adult Mental Health Service and a Community Managed Rehabilitation and Support Service Produced Enhanced Outcomes For Consumers With Complex Needs in, Robertson, et al, Forging the Future, Contemporary TheMHS in Mental Health Services, Melbourne Conference Proceedings 2013, Melbourne, Victoria, 166-171
8. Lewis, J., **Brophy, L**., Petrakis, M., Halloran,K., Stylianou, M., Scott, M., Cocks, N., Buckley, L.& Hamann, J. (2014) Outcomes from the Piloting of Two Recovery-Orientation-Of-The-Service Measures with Consumers Experiencing Severe and Enduring Symptoms of Mental Illness and Complex Needs, in Robertson, et al, Forging the Future, Contemporary TheMHS in Mental Health Services, Melbourne Conference Proceedings 2013, Melbourne, Victoria 171- 176
9. Buchanan, J., **Brophy, L**. & Joubert, L. (2014) An Exploratory Study of the Experience of Mind Consumers on Community Treatment Orders, in Light of the Recovery Paradigm in Robertson, S, et al, Forging the Future, Contemporary TheMHS in Mental Health Services, Melbourne Conference Proceedings 2013, Melbourne, Victoria 205 – 210
10. Buckley, L., Cocks, N., Scott, M., Stylianou, M., **Brophy, L**., Lewis, J., Halloran, K. & Petrakis, M. (2013). Are we recovery orientated? Learning from people with lived experience. Recovering Citizenship, Contemporary themes in Mental Health Services, The Mental Health Services Conference Inc. of Australia and New Zealand, Conference Proceedings 2012. Sydney, NSW, pp. 178-184.

OTHER PUBLICATION OUTPUTS:

1. **Brophy, L**, Politanski, C, Heeney M (2018) Using consumer engaged evaluation to support service innovation, *New Paradigm: The Australian Journal on Psychosocial Rehabilitation,* Summer, 40-44.
2. **Brophy L** (2018) Trends in research and the mental health sector: an update. *New Paradigm: The Australian Journal on Psychosocial Rehabilitation,* Summer, 9-11.
3. Mcsherry, B., **Brophy, L**., Roper,C., Tellez, J. (2017) Reducing seclusion and restraint. *The Health Advocate*, 34-35.
4. Meadows, G., Weller, P., Edan, V., Thornton, C., & **Brophy, L.** (2015). PULSAR research: making mental health services more recovery-orientated. *New Paradigm: the Australian journal on psychosocial rehabilitation*, Summer, 46-48.
5. **Brophy, L** & Grigg, M. (2015) Trends in Research in the Mental Health Sector. *New Paradigm: the Australian journal on psychosocial rehabilitation*, Summer, 07.
6. **Brophy, L**., Bruxner, A., Wilson, E., Cocks, N., Stylianou, M. & Mitchell, P. (2015) People making choices: The support needs and preferences of people with psychosocial disability: Project summary. *New Paradigm: the Australian journal on psychosocial rehabilitation*, Summer, 14-17.

7. **Brophy, L**., Bruxner, A. & Wilson, E. (2014) Consumer choices about mental health support services. *New Paradigm: the Australian journal on psychosocial rehabilitation*, Summer, 27-29.
8. **Brophy, L**. (2009). What does research tell us about good practice with people on CTOs and their carers? *New Paradigm: The Australian Journal On Psychosocial Rehabilitation*, Winter, 24-28.
9. Ring, D., **Brophy, L.** & Gimlinger, A. (2001) Examining Community Treatment Orders: A preliminary inquiry into their efficacy. *Health Issues*, 66 (March), 13-17.
10. Brophy, L. & Savy, P. (2011). Summary: Broadening the evidence base of mental health policy and practice. Health Sociology Review, 20 (2), 229-234
11. Kisely, S., Brophy, L., & Grant, K. (2019). International perspectives on community treatment orders: Special Edition. International Journal of Law and Psychiatry, 66, 3 pages. doi:10.1016/j.ijlp.2019.101489
12. Brophy, L., Roper, C., & Grant, K. (2019). Risk factors for involuntary psychiatric hospitalisation. The Lancet Psychiatry, 6(12), 974-975. doi:10.1016/s2215-0366(19)30442-0

RECENT RESEARCH REPORTS:

1. Mitchell, P., Green, R., Hawke, K., Lee, K., Svensson, E., Toh, J.W., Barentsen, C., Copeland, M. and **Brophy, L**. (2017) *Evaluation of the Frankston Youth Prevention and Recovery Care Service 2015 – 2017*. The University of Melbourne.
2. Kokanovic, R., **Brophy, L**., McSherry, B., Hill, N., Johnson-Ataata, K., Moeller-Saxone, K. and Herrman, H. (2017) *Options for supported decision-making to enhance the recovery of people experiencing severe mental health problems*, University of Melbourne: Melbourne Social Equity Institute.
3. Kakuma R, Hamilton B, **Brophy L,** Minas H, Harvey C. Models of Care for people with severe and enduring mental illness: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health, 2017
4. Hall, T., **Brophy, L**., & Jordan, H. (2016). *A report on the process evaluation of the Mind Recovery College* (2). University of Melbourne & Mind Australia.
5. Hall, T., **Brophy, L.**, & Jordan, H. (2016). *A report on the early outcomes of the Mind Recovery College: A report on the early outcomes of the Mind Recovery College*. University of Melbourne: University of Melbourne & Mind Australia.
6. Hayes, L, **Brophy, L.,** Harvey, C., Hermann, H., Killackey, E &Tellez, J. (2016) *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme: promoting psychosocial functioning and recovery.* University of Melbourne & Mind Australia.
7. Reifels, L., Hamilton, B., Roper, C., Edan, V., Fletcher, J. & **Brophy, L**. (2016) *Independent Mental Health Advocacy Service: Program Theory & Logic and the Monitoring & Evaluation Framework.* Prepared for Independent Mental Health Advocacy Service and Victorian Legal Aid.
8. Laragy, C, Sanders, F. & **Brophy, L**. (2015). *Implications for family carers when people with psychosocial disability have individualised funding packages - literature review*. University of Melbourne & Mind Australia.
9. **Brophy, L**., Williamson, M., McKenzie, R. & Roper, C. (2015) *Mind Australia's Peer Recovery Communities: An implementation evaluation.* Centre for Mental Health and Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne.
10. **Brophy, L.,** Bruxner, A., Wilson, E., Cocks, N., Stylianou, M. & Mitchell, P. (2014). *People making choices: the support needs and preferences of people with psychosocial disability.* Mind Australia.
11. Fletcher, J., Sutherland, G., **Brophy, L.,** Hamilton, B., and Kinner, S. A. (2014). *Least restrictive practices in acute mental health wards including consideration of locked doors: A literature review and recommendations for future practice.* Prepared for the Queensland Mental Health Commission.
12. Fletcher, J., Hamilton, B., King, K., Sutherland, G., Kinner, S. A. & **Brophy, L**. (2014). *Least restrictive practices in acute mental health wards including consideration of locked doors: Facilitated forums and options for the future.* Prepared for the Queensland Mental Health Commission

13. McSherry, B., Clinton, J., Harvey, C., Kinner, S., Hamilton, B., **Brophy,L**., Roper, C., Kaempf, A., Gooding, P., Al-Nawaab, H., Wilson, K. & Tellez, J.(2014) *Seclusion and Restraint Project: Report.* Prepared for the National Mental Health Commission.

SELECTED CONFERENCE PRESENTATIONS:

1. **Brophy, L.** *Mental Health Social Work in Australia, Addressing the big challenges.* The distinctive contribution of social work to mental health. Launch event for the Reflections on Mental Health Social Work. Queen's University June 2019. Belfast, Northern Ireland. **Invited Speaker.**
2. **Brophy, L.** *Supporting people with psychosocial disability - the evidence, opportunities and challenges - an update.* Psychosocial Support Services (national psychosocial support measure) Murray Primary Health Network Forum, April 2019. Bendigo. **Invited Speaker**
3. **Brophy, L**, Ryan, C and Weller, P. (2018). *Reducing the use of coercive interventions including Community Treatment Orders - promising alternatives and the core importance of Supported Decision Making.* World Psychiatry Association Thematic Congress, February 2018. Melbourne.
4. **Brophy, L. (2017)** *Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems.* The Inclusion Days of the Federal Ministry of Labour and Social Affairs. Germany. December 2017. Berlin. **Invited Speaker**
5. **Brophy, L**., Palmer, V. and Hopgood, F. (2017). *Building social inclusion through empathy.* The Inclusion Days of the Federal Ministry of Labour and Social Affairs. Germany. December 2017. Berlin. **Invited Speaker**
6. **Brophy, L** (2017) *Effective, Evidenced Based Interventions Suitable for Early Intervention in the NDIS: Promoting psychosocial functioning and recovery.* The 1st National Disability Insurance Scheme (NDIS) and Mental Health Conference, Sydney. November 2017. **Invited Keynote Presentation.**
7. **Brophy, L** (2017) *Being recovery oriented and reducing the use of restrictive interventions in mental health care –finding solutions together.* The Bendigo Health Psychiatric Services and Western Education and Training Cluster annual forum. October 2017. **Invited Keynote Presentation**
8. **Brophy, L.** (2017) *The Mind Australia Recovery College: A co-designed process evaluation* Recovery College International Community of Practice Symposium. Boston University. August 2017
9. Roper, C. and **Brophy, L**. (2017) *Doing Supported Decision-Making 'On the Ground': Learning About Enablers and Barriers in the Context of Mental Health in Victoria, Australia.* XXXVth International Congress on Law and Mental Health. Charles University, 9 to 14 July, Prague, Czech Republic.
10. **Brophy, L**. (2017) *Community Treatment Orders in the context of the supported decision making and recovery orientated practice.* XXXVth International Congress on Law and Mental Health. Charles University, 9 to 14 July, Prague, Czech Republic.
11. O'Connor, N, Ryan, C, Keller, A. Newton-Howes, G. Nance, M. and **Brophy, L**. (2017) *Community Treatment Orders Are Largely Ineffective and Their Use Should Be Scaled Back Dramatically* (Combined Symposium Presentation/Debate) Royal Australian and New Zealand College of Psychiatrists' Annual 2017 Congress, 30 April - 4 May, Adelaide
12. **Brophy, L**. (2017) *The implications of Supported Decision Making to Social Work practice in mental health.* Mental capacity and professional decision making in social work, Department of

Health, 22nd March 2017, Templepatrick, Northern Ireland, UK (**invited key note presentation** via video)

13. **Brophy, L**. (2016) *CTOs and perspectives on Supported Decision Making.* ASSA-funded Workshop. Monash University Law Chambers, September, 2016.
14. **Brophy, L**. (2016) *The implications of Supported Decision Making to Social Work practice in mental health.* Enhancing the Human Condition: 8th International Conference on Health and Mental Health, 19th to 23rd June, Singapore. 2016.
15. Weller, P., Owens, N. **Brophy, L.**& Carey, S. (2016). *Are we supporting the disempowered? Early experience of Mental Health Tribunal hearings under the new Mental Health Act in Victoria Australia.* Symposium, International Congress of Psychiatry 8-12 May 2016 Hong Kong.
16. McSherry, B., Herrman, H., Kokanovic, R.& Brophy, L.(2015) *Supported Decision Making Symposium.* Conference of the Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL) November 2015. Canberra.
17. Hamilton, B, Fletcher, J. & Brophy, L. (2015) *Working towards least restrictive practices in mental health inpatient units.* The Mental Health Services (TheMHS) conference, August 2015. Canberra
18. **Brophy, L**. & Jayakody, E. (2015) *Supporting the Introduction of Advance Statements in Victoria, Australia.* 34th Congress of the International Academy of Law and Mental Health, July 2015. Vienna
19. **Brophy, L**. (2015) *The perspective of people with lived experience of mental health issues on how to reduce seclusion and restraint.* 34th Congress of the International Academy of Law and Mental Health, July 2015. Vienna
20. **Brophy, L** (2015) *Mental Health Advance Statements in the Victorian Mental Health Act, 2014.* Mind Community Conference, May, 2015. Melbourne
21. **Brophy, L**., Roper, C., Hamilton, B., Tellez, J. & McSherry, B. (2015) *Consumer and Carer perspectives on strategies to reduce seclusion and restraint in mental health settings.* 10th National Seclusion and Restraint Reduction Forum, May 2015. Melbourne
22. Hamilton, B., Roper, C., and **Brophy, L.** (2015) *Consumers and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings.* Qualitative Methods Conference, April 2015. Melbourne
23. **Brophy, L**. (2015) *The Challenge for Mental Health Social Workers under Individualised Care Arrangements for NDIS.* World Social Work Day Western Education and Training Cluster Event in March 2015 Melbourne **Invited Keynote Presentation**
24. **Brophy, L**.,Bruxner, A., Wilson, E., Cocks, N.& Stylianou, M (2014) *People with psychosocial disability and the national disability insurance scheme – if we had a choice – what would we want?* Melbourne Social Equity Institute Conference, August, 2014. Melbourne,
25. **Brophy, L.,** Bruxner, A., Wilson, E., Cocks, N.& Stylianou, M. (2014) *Talking to people with psychosocial disability: how to facilitate discussion about their preferences for treatment, support and care in the context of the NDIS.* The Mental Health Services Conference (TheMHS) August 2014. Perth.
26. **Brophy, L** (2014) *People making choices: the support needs and preferences of people with psychosocial disability.* 2nd National Integrating Mental Health into the National Disability Insurance Scheme Conference. November 2014 Sydney **Invited Keynote Presentation**
27. **Brophy, L**. (2014) *The National Disability Insurance Scheme (NDIS) and its responsibility to ensure that the rights and life aspirations of those with psychosocial disabilities are achieved.* Joint World Conference on Social Work, Education and Social Development. June 2014. Melbourne
28. **Brophy, L**.,Bruxner, A., Wilson, E., Cocks, N.& Stylianou, M (2014) *Consumer choices about mental health support services,* National Disability Services Conference May 2014. Sydney

29. **Brophy, L**., Bruxner, A., Cocks, N.& Stylianou, M. (2014) *People making choices about mental health treatment and care - Barwon pilot research project.* Mind Australia Community Conference, April 2014. Melbourne
30. **Brophy, L.** (2013) *Ethical, Policy and Legal Challenges in supporting people on CTOs*, Centre for Mental Health Social Research Seminar. York University UK, July 2013
31. Brophy, L., Harvey, C., Grigg, M., Moeller-Saxone, K., & Siskind, D. (2013). *Recovery enhancing service delivery in the community managed (or non government) sector.* The Mental Health Services (TheMHS) Conference 2013. Melbourne
32. Buchanan, J., & **Brophy, L.** (2013). *Community treatment orders in the context of recovery.* The Mental Health Services (TheMHS) Conference 2013. Melbourne
33. **Brophy, L.,** Weller, P., Sylvester, W et al (2013) *Consumers of Mental Health Services making Advanced Statements - The challenges and opportunities* (featured symposium) The Mental Health Services (TheMHS) Conference 2013. Melbourne
34. McSherry, B., **Brophy,** L. & Roper, C. (2013) *Working together to reduce and eliminate seclusion and restraint – a National Mental Health Commission initiative in collaboration with The University of Melbourne.* The Mental Health Services (TheMHS) Conference 2013. Melbourne
35. **Brophy, L**.& Loh , M. (2012) *PARC exit survey findings.* VICSERV Conference: Melbourne
36. **Brophy, L.** (2012) *What do we know about research into recovery?* VICSERV Conference: Melbourne
37. Harvey, C. & **Brophy, L.** (2012) *Psychiatric Disability and Rehabilitation Support Services and the Survey of High Impact Psychosis.* VICSERV Conference: Melbourne
38. **Brophy, L**. (2012) *Outcome Measurement in Mind.* Mind Australia, Victorian Staff Conference
39. **Brophy, L**. (2012) *Research for Improving Practice, Policy and Law.* Mental Health and Social Work Research Conference, The University of Queensland 2012. - **Invited Keynote Presentation**:
40. **Brophy, L**. (2011) *Principles of good practice with people on CTOs.* Association of Mental Health Social Workers (AMHSW) 2 Day Conference: Dignity, Hope and Recovery 6th and 7th October 2011 - **Invited Keynote Presentation**
41. **Brophy, L** (2011) Principles *of Good Practice with People on Community Treatment Orders.* Mind Australia South Australia Staff Conference 2011
42. **Brophy, L**. (2011) *Community Treatment Orders and Law Reform in Victoria, Australia*,32nd Congress of the International Academy of Law and Mental Health, Berlin, July 2011
43. Owens, N. & **Brophy, L.** (2011) *Revocation of Community Treatment Orders,* 32nd Congress of the International Academy of Law and Mental Health, Berlin, July 2011
44. **Brophy, L** (2010) *Ethics and Values in Mental Health Social Work Research.* Postgraduate research in Social Work in Mental Health Conference, 15th July, Brisbane, **Invited Keynote Presentation**
45. **Brophy, L.** (2010) *What represents good practice with people on Community Treatment Orders?* (2010) 6th International Conference on Health and Mental Health, 28th June to 2nd July. Dublin, Ireland

AWARDS

1. How Social workers can contribute in the shift to personalised, recovery oriented psychosocial disability support services. *Oral Presentation Service Settings Award* at Enhancing the Human Condition: 8th International Conference on Health and Mental Health, 19th to 23rd June, Singapore. 2016.
2. The Director of Research – Mind Australia. *Tom Trauer Research and Evaluation Award, for excellence in research supporting advancement of mental health services.* TheMHS Awards for service to Mental Health August 2015. The MHS Learning Network

3. Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards in Queensland. *Letter of Commendation* TheMHS Awards for service to Mental Health August 2015. The MHS Learning Network
4. The New Initiatives Evaluation – 2013. *Mental Health Service Achievement Special Judges' Commendation in the Consumer-Provided category.* TheMHS Awards for service to Mental Health August 2015. The MHS Learning Network.
5. What represents good practice with people on Community Treatment Orders? *Oral Presentation Service Settings Award* at Changing Health: 6th International Conference on Health and Mental Health, 28th June to 2nd July. Dublin, Ireland, 2010.
6. Association of Mental Health Social Workers award for *Recognition of Exceptional Practice in Mental Health Social Work* – October 2011