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Reasons behind the rise in involuntary psychiatric treatment under mental health act 2016, Queensland, Australia – Clinician perspectives

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ABSTRACT

Objective: Despite legislative reform to promote less restrictive treatment options, the rates of involuntary psychiatric treatment in Queensland, Australia continue to rise. This paper aims to investigate mental health clinicians' perspectives of reasons behind the high and increasing rates of involuntary psychiatric treatment in Queensland.

Method: Qualitative methodology was used to explore clinician perspectives by facilitating two face-to-face focus groups. Purposive sampling was used to select clinicians of multiple disciplines from inpatient and community adult mental health teams. Reflexive thematic analysis was utilised to analyse and interpret data.

Findings: The findings suggested a broad consensus that involuntary treatment is over-utilised in public mental health services. Six main themes were identified, including risk aversion, systemic service deficiencies, lack of voluntary alternatives, increased substance use in the community, legislative and policy shortcomings, and barriers to enacting criteria in the legislation.

Conclusion: This paper highlights that legislative reform alone will be ineffective in reducing involuntary psychiatric treatment, and adequate resources, training, policy and culture change are necessary for successful implementation of less restrictive practices. The reforms require reorientation of the implementation of policy, as well as legislation to align the Queensland mental health system within a human rights framework.

1. Introduction

Involuntary psychiatric treatment is a contentious issue in medicine due to human rights implications and clinical and ethical concerns (O'Donoghue et al., 2016). Involuntary psychiatric treatment broadly refers to practices involving implicit and explicit pressure or force, imposed via legal means on individuals usually diagnosed with a mental illness who are refusing treatment (Martinho et al., 2022; Sashidharan et al., 2019). Encompassing a broad range of interventions, treatment can include injection or ingestion of psychotropic medications, electroconvulsive therapy, behavioural controls such as seclusion and restraint, admission to hospital, and supervision and monitoring in the community (Barbui et al., 2021; Gooding et al., 2020; Sashidharan et al., 2019).

There are several terms that refer to involuntary treatment orders which vary across countries and jurisdictions and whether the order applies to the inpatient or community setting (Goulet et al., 2020). Common examples include Involuntary Treatment Order (ITO), Community Treatment Order (CTO), and Compulsory Community Treatment (CCT) (Goulet et al., 2020). In most countries, mental health legislation outlines the criteria and conditions for involuntary psychiatric treatment, which can be ordered to take place in an inpatient setting or in the community (Brophy et al., 2021). Mental health legislation stipulates processes for the enactment of interventions to be carried out by authorised mental health services and clinicians (Light, 2019). Enacting involuntary psychiatric treatment requires clinicians to weigh and balance ethical tensions such as an individual's right to dignity, autonomy, and self-determination against a duty of care and community safety (Carpiniello & Wasserman, 2020).

Involuntary psychiatric treatment has been broadly accepted in society not only because it is sanctioned in legislation and policy, but because of the perception that it is necessary to protect people from aggression or harm to self (Chumakov et al., 2021). The evidence for involuntary psychiatric treatment however is ambiguous. Empirical

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evidence from randomised control trials of CTOs alongside anecdotal evidence has indicated there are limited to no benefits in relation to reduction in relapse rates, length of hospital admissions, and improvement in treatment adherence of service users' quality of life (Kisely et al., 2017; Mikellides et al., 2019; Rugkåsa & Burns, 2017). The experience of involuntary psychiatric treatment for mental health service users is associated with some benefits and several disadvantages (Saya et al., 2019). Benefits may include increased access to mental health services that can be perceived as supporting recovery and acting as a safety net for relapse (Goulet et al., 2020). However, service users' perspectives involve predominantly negative experiences of emotional and cognitive reactions including a loss of freedom and dignity, shame, self-contempt, and increased stress associated with self-stigma (Rüsch et al., 2014; Solomon & Petros, 2020). Involuntary psychiatric treatment is often experienced as punitive through forced pharmacological treatment, the threat of recall to hospital when refusing treatment, and the negative impact of stigmatising effects on many other areas of a person's life and a person's long term recovery (Goulet et al., 2020; Puras & Gooding, 2019).

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) adopted in 2006 challenges the traditional mental health legislation by emphasizing the respect for inherent dignity, universal legal capacity and physical and mental integrity of persons with disabilities (Callaghan & Ryan, 2014; Gill & Sartorius, 2024; United Nations, 2006). The CRPD insists on the respect for autonomy and right to self-determination (Škorić, 2019; Sugiura et al., 2020). The World Health Organization (WHO) QualityRights project, based on key articles of the CRPD, provides guidance on quality improvement and human rights protection and promotion for persons with lived experience of psychosocial disabilities (World Health Organization, 2021). The World Psychiatric Association (WPA) adopted a position statement on implementing alternatives to coercion in mental health care (Herrman et al., 2022; World Psychiatric Association, 2020). The WHO and WPA have also jointly highlighted the important overarching goal to work together to address coercion in mental health care (Gill et al., 2024).

Despite these developments, reliance on involuntary psychiatric treatment remains widespread in mental health services globally and with rising rates worldwide, calls to action have intensified (Puras & Gooding, 2019). In recent decades, involuntary psychiatric treatment in the community has been expanding globally and is now used in more than 75 jurisdictions worldwide (Mikellides et al., 2019). While advocates of Community Treatment Orders argue it is less restrictive than hospital admissions and supports service users to establish stability in their lives, opponents' contend that it can undermine the therapeutic relationship through an emphasis on the clinicians' power and control (Kisely et al., 2019). Some commentators have suggested that the move from institutional care to involuntary psychiatric treatment in the community has merely shifted the location in which coercive practices take place, and as such the dominant paradigm of medical paternalism never really went away (Gilhooley & Kelly, 2018; Gooding, 2016; O'Donoghue et al., 2016).

The literature shows evidence of the limits of what legislative reform alone can achieve, but evaluations of the impact of legislative changes have signified the need to understand the implementation issues in practice. In addition to variances in legislation, there is a myriad of political, ethical, and organization factors operating in any one context that could be contributing to different rates of involuntary psychiatric treatment. It has been proposed that understanding clinicians' perspectives around why involuntary treatment is being used could contribute towards developing knowledge around the factors driving the increase in involuntary treatment (Light, 2019). The perspectives of those making decisions about the use of involuntary treatment should be explored to inform potential strategies to reduce reliance on involuntary psychiatric treatment (Freeman et al., 2015; Light, 2019).

This study aims to identify legislative, administrative, systemic, and cultural factors associated with the rise of compulsory treatment, despite attempts to introduce several less restrictive options from the viewpoints of clinicians working with service users subjected to involuntary treatment under the Mental Health Act, 2016, in Queensland, Australia. It is crucial to understand the reasons behind the rise of involuntary treatment, despite legislative efforts to provide less restrictive treatment.

2. Method

2.1. Study design

A qualitative methodology design was utilised to investigate clinician perspectives of increasing rates of involuntary psychiatric treatment in Queensland, Australia. This study forms a part of a larger research project which aims to triangulate the perspectives of persons with lived experience of mental illness, family/carers, clinicians and lawyers to investigate the reasons behind the rise in involuntary psychiatric treatment in the state of Queensland.

2.2. Study context

This study was conducted in a large public mental health service in a metropolitan area in Queensland, Australia, comprising of inpatient and community mental health services for child and youth, adult and older persons. The Mental Health Act, 2016 (Qld) was implemented in March 2017 to align with the CRPD by emphasizing the importance of considering 'least restrictive treatment' and outlining safeguards that promote alternatives to involuntary treatment, signifying a move towards protection of human rights (Gill et al., 2020). There are three categories of involuntary treatment orders under Mental Health Act, 2016 (Qld): Forensic Order (FO), Treatment Support Order (TSO) and Treatment Authority (TA). Forensic Order and Treatment Support Order are applied for compulsory treatment of patients who have been diverted from the criminal justice system because of unsoundness of mind or unfitness for trial due to a mental illness. Treatment Authority (TA) is the involuntary treatment order for civil commitment when a psychiatrist determines that the person has a mental illness, lacks capacity to consent to treatment and there is an imminent risk of harm to self or others or risk of serious mental or physical deterioration in the absence of involuntary treatment. Each type of order, FO, TSO and TA can be either inpatient or community category. The Mental Health Act*, 2016* (Qld) introduced several less restrictive measures to ensure treatment, including Advance Health Directive, Nomination support person and statutory health attorney etc. Despite this new legislation which aims to enhance patient autonomy and offer less restrictive alternatives, the rates of involuntary psychiatric treatment are not only high but also rising in Queensland, Australia (Gill et al., 2020).

2.3. Data collection and recruitment

Data were collected using face-to-face focus groups (FG's) comprising of clinicians working within mental health services of a metropolitan area of Queensland. The group dynamic promoted an interactive environment encouraging communication between participants to stimulate discussion and generate ideas together. The focus groups were moderated by one researcher, with two co-researchers present, in line with the best practice recommendations to assist with observations, notetaking, managing disruptions, and post facilitation debriefing (Liamputtong, 2020). Critical points were summarised throughout the focus groups. To answer the research question, several prompting questions were prepared. Focus groups were held during last hour of the workday and lasted between one to two hours, to achieve minimum impact on clinical time while limiting the burden on personal time. Audio-recording devices were used for the focus groups, alongside notetaking during and immediately afterwards. Audio-recordings were transcribed verbatim by a third-party transcription service and were destroyed after checking for accuracy against the transcribed data.

2.4. Sampling and recruitment strategies

This research utilised criterion sampling – a type of purposive sampling where participants meet pre-determined characteristics (Gray, 2021). This included clinicians working with involuntary service users to ensure they possessed experience of working with the Mental Health Act, 2016 (Qld) to enable relevant contributions. This was achieved through eligibility for inclusion requiring clinicians to be either an Authorised Mental Health Practitioners or Authorised Doctors. The focus groups aimed to include representation from all disciplines within the multidisciplinary teams, including doctors, nurses, and allied health professionals. Inpatient, acute, and continuing care teams within a large metropolitan adult mental health service were included.

The participants were recruited with an expression of interest circulated via email to team leaders of inpatient, acute and community teams within the service. A purposeful selection was undertaken to balance representation of clinicians from different teams, professions, and years of experience.

2.5. Data analysis

Data were analysed inductively using the six phases as outlined by Braun and Clarke (2022). The first phase involved familiarisation with the data by listening to the recordings and reading the transcripts. Codes were developed inductively by identifying relevant or meaningful segments in relation to the research question and applying code labels–from semantic to latent descriptions. In this way the data were captured with code labels collated and relevant segments for each code compiled (Braun & Clarke, 2022). The initial themes were then generated from these codes. In the next phase the themes were scrutinised and verified to ensure that they made sense in relation to both the full data set and the coded extracts. They were then refined, defined and named to ensure that there was a clear demarcation of each theme. These themes were then re-applied to the full dataset. During the write up, these were then combined together into a coherent narrative that includes vivid data extracts (Braun & Clarke, 2022). The themes are presented based on the prominence in the discussions.

3. Results

3.1. Description of the sample

Two focus groups were held, each group consisting of seven participants of mixed disciplines (total sample size = 14). The participants included a consultant psychiatrist (1), psychiatry registrars (3), clinical nurse consultants (3), clinical nurses (3), social workers (3) and a psychologist (1).

3.2. Overarching experiences

Clinicians considered it was important to provide treatment in the least restrictive manner and that involuntary psychiatric treatment was over-utilised in public mental health services. While this was the case, participants described many barriers to working in least restrictive ways. The main determinants identified by clinicians as contributing to high and increasing rates of involuntary psychiatric treatment were focussed on the following themes: risk aversion, systemic service deficiencies, lack of voluntary alternatives, increased substance use in the community, legislative and policy shortcomings as well as inherent barriers within the legislation, including the criteria for involuntary treatment in the Mental Health Act, 2016 (Qld) legislation. Below we will expand on each of these themes.

3.3. Risk aversion

Clinicians believed that, in general, the mental health service and many clinicians practiced in risk averse ways. Risk aversion was one of the strongest themes in both focus groups. Clinicians described how their practice was strongly influenced by the impact of high-profile adverse events and the perceived blame in the aftermath of these events. This thinking influenced practice when there was a possibility of scrutiny from the public and sensationalist accounts from media; when mental health services had the potential to be portrayed as neglectful when an untimely event occured after a revocation of a Treatment Authority (TA).

"Sometimes it [TA] is driven not by people's mental illness but the fact that there could be adverse repercussions for a service […] we look at putting people under the Act, not under the guise of a mental illness – there are reasons – but more driven by, how is this going to look in the newspapers."

"We get a lot of feedback on social media, in the newspapers. as soon as […] there's something significant happening, it's like, where were mental health? What were they doing? They weren't actually given help. Then we feel that we need to keep that TA in place a lot longer."

Similarly, the perceived personal and professional repercussions following an adverse event were described as influencing the use of involuntary psychiatric treatment. Some clinicians questioned how well they would be supported by the service if an external review of the incident indicated that treatment was not assertive enough. Clinicians perceived psychiatrists to be more risk averse as they generally held the overall responsibility, and subsequent blame, following an adverse event.

"Yeah, even the lead up to the coroner's court, you just – you're going through a lot of stress … I've seen doctors in tears [before a] coroner's court appearances… months before they're even due to appear, it's a stressful, stressful thing, and the worry, the concern, you know."

"We've had a couple of external reviews, which suggested that we probably weren't assertive enough… it had a big impact on the general culture for most of the psychiatrists."

"But at the end of the day the psychiatrist is the person that wears the decision at the end … There was a situation here a couple of years ago where [high profile adverse event]… and the poor psychiatrist copped a lot…."

In addition to the potential of personal and professional negative impact of adverse events, clinicians spoke about the increase of involuntary treatment when service users were diverted from the criminal justice system to the mental health system. It was noted that service users with forensic history were more likely to be perceived as a major risk and subsequently receive restrictive treatment. It was noted that service users who are incarcerated while being under a TA in the community generally remain under involuntary psychiatric treatment much longer.

"In terms of how we view people who have been diverted from the criminal justice system… we can be quite discriminatory towards them… [we are] more likely to be restrictive with them".

"When someone presents at ED and they have an antisocial personality disorder or they've been in [prison]… we then view them as a major risk and we're like, oh, they're in the hard basket, they've robbed a shop, and then a TA will get implemented."

"There's a lot of people that get started on TA and then go into the system, and I've almost never heard of anyone saying, look, this person is really well, maybe you should look at revoking the TA… there's information coming from that side that…We're not sure how things will be when he's going to come out… they are on a TA three years down the line."

Clinicians described about how at the heart of restrictive practices was the belief that involuntary treatment somehow prevents critical incidents from occurring. This belief influenced what one clinician described as a variation in the degree of conservative and paternalistic practice between teams.

"Some teams are inherently more conservative and paternalistic. Sometimes the clinical leadership of some psychiatrists is of that type, which then makes it difficult for clinicians, like registrars, case managers… to say that we would like to move forward with trying to revoke the TA… there's usually a false belief that The Mental Health Act is somehow preventing critical

incidents, when it's not. I think it's more in our heads. In practice it's not really doing what we think it's doing."

3.4. Systemic service deficiencies

Systemic service deficiencies were seen to influence the use of treatment authorities. Clinicians spoke about high workloads and having limited time to spend with service users. The burden of administrative and managerial tasks contributed to this workload. Furthermore, the high turnover of clinicians and limited access to consultant psychiatrist appointments impacted on continuity of care for consumers. These high workloads and turn over limited the clinicians' time to provide therapeutic interventions which could support less restrictive options.

Clinicians also described how high demands on hospital beds reduced the length of inpatient stay and as a result increased acuity in the community. Moreover, there was a high demand for community services. While there was a strong push to discharge service users to the care of General Practitioners to accommodate new referrals, there were limited care options outside of public mental health services. Indeed, primary care services are also stretched, and many GPs do not have the time or specialist skills to support this high need group. As a result, clinicians described a lack of voluntary alternatives for patients, within a high demand, under-resourced mental health service and that involuntary treatment was often used as a safety net to ensure access to treatment. The lack of availability and affordability of services was also a concern for families who, for these reasons often pushed for the person to remain under the treatment authority.

"Sometimes it's a lack of resources and a lack of access to consultants that means that clients get stuck on treatment authorities longer than necessary, because we don't have that readily available access to consultant appointments… that means that clients are on TAs for weeks or months longer than they need to…".

"I think a lot of people…. keep them on TAs so that it enforces the community team to follow up…. Because its hard to get case management sometimes".

"Families see involuntary treatment as a safety net and of course their big concern is that when you start talking about revoking the treatment authority, they think that you're going to rip up the treatment authority and not be involved. So, for some people it's a really good safety net, the treatment authority. It kind of ensures treatment."

In addition to the pressure on the mental health care system, clinicians noted an increase of presentations involving substance use. This meant that, service users who presented to the service had an increased risk profile and that assessments and treatments for this group were more complex. Clinicians believed that TAs were often used as a protective factor for this group as there were limited Alcohol and Other Drug treatments available.

"I think also resources in drug and alcohol is a big area that we could improve on because if we had more pathways for drug and alcohol support, I think that lots of people who are on treatment authorities just for that protective factor."

3.5. Legislative and policy shortcomings

In addition to risk aversion, increased service demand and acuity, clinicians also described how different legislative requirements, directives and policies did not enable clinicians to provide care in the least restrictive ways. Similarly, some clinicians perceived that there was also a lack of leadership and support to encourage working with service users on a voluntary basis.

"It would be good to hear a direction from above that, we want to get people on voluntary engagement and still be able to keep them open on the books, and if anything bad happens or they disengage, then we've got you. But I wouldn't have a lot of confidence in that, not that that would override your clinical rationale, but it's something subconscious in the system."

Similarly, legal mechanisms such as the Mental Health Review Tribunal (MHRT) which were introduced as an independent review body were perceived to focus on maintaining people on a TA, rather than reviewing the need of these. The MHRT was perceived by clinicians as risk averse and some expressed doubt about their partiality and independence.

"In your standard MHRTs I've never been in one where the tribunal really showed any interest in revoking the TA. They just go, yeah, that's what the report says, and without any real… - they take the report and not much else. Honestly, a lot of the time it feels like a waste of resources, because they're not going to go against what the treating team has said."

3.6. Barriers to enacting provisions within the mental health act

The inclusion of the criterion that a person must lack capacity to consent to be treated involuntarily for a mental illness in the legislation was seen as having little bearing on clinical decisions regarding involuntary psychiatric treatment. Clinicians identified having a poor understanding of the assessment of decision-making capacity and regarded it more as a vague judgement that is open to interpretation. Moreover, the emphasis on service user's stability of capacity or longitudinal capacity for decision-making was regarded as a caveat or free pass to enable involuntary psychiatric treatment. The impression that capacity could be implicated in justification for involuntary psychiatric treatment when service-user's views differ to the treating team was also raised. In these instances, risk was determined to override capacity criteria. It was noted that many clinicians did not receive appropriate training as to how to assess for capacity.

"It's so open to interpretation, that idea of capacity. There's so much variation."

"Yeah, and assessing capacity; you know, you've got an influx of new clinicians and that could be the beginning clinicians, where do they learn to actually assess capacity, what does that actually mean?"

While voluntary treatment is the least restrictive option within the Mental Health Act, 2016 (Qld), other provisions in the act allow clinicians to deliver care in the least restrictive way. The less restrictive options for treatment for adults include Advance Health Directives (AHDs), nominated support person, and statutory health attorney. It was noted however that there was very limited information and training as to how to use these. Furthermore, to develop these requires time, which was often lacking. Participants noted that they felt that many clinicians lacked training and understanding of the process.

"I've had no training or awareness of any training about it [advance health directive] at all."

"there is lack of knowledge as to who could start that process [AHD] and who could contribute to completing that… It's the lack of knowledge around you using it, some of those resources."

4. Discussion

This research aimed to explore clinicians' perspectives as to why the rates of involuntary psychiatric treatment are still high and increasing, despite the introduction of several less restrictive ways of treatment in mental health legislation. Overall, the findings suggest that clinicians perceive increasing rates of involuntary psychiatric treatment are situated within a resource constrained system which is dominated by a risk averse culture that obstructs less restrictive, recovery-oriented practice. The influence of paternalism in mental health have not only influenced historical service development but continue to pervade contemporary mental health service provision. This research suggests that legislative reform without robust implementation strategies that involve adequate resourcing and training for those tasked with applying and reviewing the use of involuntary psychiatric treatment will fail to rise to the challenge of improving fundamental human rights for service users accessing treatment. The substantial discretion afforded to mental health clinicians to enact involuntary treatment via mental health legislation (Beaupert, 2018; Fennell, 2010; Solomon & Petros, 2020) highlights how important it is to include mental health clinicians in the conversation about reducing involuntary psychiatric treatment in practice (Barbui et al., 2021).

4.1. Legislation without robust implementation strategies

The findings of the paper identified that while clinicians would like to work in less restrictive ways there are several barriers' clinicians face in the implementation of less restrictive treatment options. This affirms the idea that existing rights framework within legislation has not been strong enough to affect change regarding promoting rights of dignity and self-determination (Maylea et al., 2021). Clinicians in this study reported inadequate training and education, and ambiguity in assessing decision making capacity, which has been reported as contributing to difficulties for clinicians elsewhere (Mahomed et al., 2018). These findings support claims in the literature that to be effective, the legislation needs to not only be robust in its commitment to human rights principles, but to be supported by adequately resourced services (Maylea et al., 2021).

4.2. Resource limitations and the revolving door

The findings affirmed suggestions in the literature that involuntary psychiatric treatment is being used as an administrative mechanism to signal who is deemed most in need of treatment – thereby ensuring access to treatment within low resourced and high demand public mental health services (Brophy et al., 2019; Light et al., 2014). It is important to note that the issue is characterised by a lack of voluntary alternatives available in the community and within primary care services. Alternatives in the community are scarce and include gaps in access to treatment due to extensive wait lists, services at capacity, strict eligibility criteria and a lack of services available for crisis care.

4.3. Shifting the culture of mental health services

The risk averse culture of mental health services was interpreted as being pervasive throughout clinical decision making to initiate or continue involuntary psychiatric treatment. Risk management was frequently cited as being influenced by potential personal or professional consequences of less restrictive practices, and/or the perceived ethical obligation to maintain duty of care. It was further reinforced by external factors including external reviews following adverse events contributing to a culture of blame, MHRT process or perceived pressure from families and carers to maintain involuntary treatment. Clinicians participating in this study expressed concern about the overuse of involuntary psychiatric treatment and identified the negative impacts of involuntary treatment on their relationship with service users and families. However, these insights were observed to compete with perceived ethical responsibility to consider their duty of care to service users (Brophy et al., 2019).

Current literature has identified that service users and their carers perceive a power imbalance in their engagement with services (Gooding, 2017). The clinicians participating in this research not only acknowledged this challenge, but also described power differentials within the service impacting on their own ability to advocate and support a reduction in the reliance on involuntary psychiatric treatment in practice. The clinicians who participated in this study referred to a lack of resources through high caseloads and limited time for opportunities for shared decision making amongst the multidisciplinary team to support less restrictive treatment options. The hierarchical system in mental health services was also prominent in these findings, where psychiatrists were seen to hold the authority and power over decision making, though this was accepted through the awareness that psychiatrists appear to bear the burden of blame when an adverse event occurs (Brophy et al., 2019; Goulet et al., 2020). The historical influence of medical dominance and paternalism within mental health services is demonstrated in these findings as continuing to impact contemporary service provision and impede components of empowerment and dignity for service users (Kelly, 2015).

One consequence of the risk averse culture underpinned by paternalism that impacts decision making recognised by clinicians is the missed opportunity to promote the dignity of risk, whereby service users are denied opportunity for autonomy and self-determination through overprotective practice (Parsons, 2008). The literature affirms that clinician risk aversion inhibits positive risk taking, or opportunities to promote the dignity of risk which is considered fundamental to the recovery process (Crowe & Deane, 2018; Parsons, 2008). The findings of this paper support the need for a more balanced approach to risk management where opportunities for services users to make choices and take changes are promoted. Models of care and clinical governance frameworks like Safewards, 'Six core strategies' to minimise and try and eliminate seclusion and restraint, and other measures advocated by the WHO QualityRights initiative and WPA position statement on implementing alternatives to coercion can be adopted to address coercive practices and improve quality and human rights in mental health care (Bowers et al., 2014; Huckshorn, 2004; World Health Organization, 2021; World Psychiatric Association, 2020).

The literature suggests that systems present a barrier to the dignity of risk through external pressures from families and carers (Parsons, 2008). Clinicians are situated in systems where institutional pressures exist that create the dilemma of both supporting the right to autonomy, while being charged with responsibility of preventing harm to service users and others (Angell, 2016). Therefore, overt support from leadership to minimise involuntary psychiatric treatment and promote less restrictive options will be required to support clinicians in practice (Sashidharan et al., 2019). To challenge and change risk averse culture and practices within an organization, it will be necessary to engage in examining and addressing the related culture of blame that is perceived by clinicians following adverse events. However, there is limited research on effective ways to achieve change in service or management cultures (Gooding et al., 2020).

4.4. Limitations

The current study employed purposive sampling and aimed to explore the clinicians' perceptions and understandings of legislative, administrative, systemic, and cultural factors associated with the rise of compulsory treatment. The qualitative methodology allowed for an in-depth exploration and understanding of these experiences. It is important to note however that the relatively small sample limits some of the transferability of the findings to other contexts. We used a maximum variation sampling approach and purposively recruited a mix of acute care and continuing care clinicians from different disciplines and experiences to address some of these concerns. The sampling strategy allowed us to capture a wide range of perspectives and as such enhanced the findings' generalisability. Furthermore, throughout the interviews we actively sought out dissenting opinions and experiences. While the experiences may be specific to Queensland, Australia context, many of the themes identified in this study strongly resonate with those described in the literature. However, given relatively small sample, further in-depth qualitative research of this phenomenon is recommended. Our focus groups with lawyers, and semi-structured interviews with persons with lived experience and family/carers as other subprojects of the overall research will help provide different perspectives.

5. Conclusion

The findings of this research contribute towards efforts to understand the phenomenon of increasing rates of involuntary psychiatric treatment in mental health services. The perspectives of clinicians who participated in this research suggest that they are not only ready and willing to embrace change, but they are also already acutely aware and challenged by many of the barriers and embedded practices that prevent them from working within a more recovery and rights-based orientation. Overall, this research has confirmed that legislative reform alone will be ineffective in reducing involuntary psychiatric treatment, and adequately resourced and trained clinicians are necessary for successful implementation of less restrictive practices. To bring about change adequate resourcing and training accompanying legislative reform are necessary to enable clinicians to practice in the least restrictive ways. Considering the major finding from this research that risk averse and paternalistic culture of mental health services are impeding less restrictive options, undertaking work on organisational culture change within mental health services would be highly beneficial. This would include strong leadership to bring about culture change and ensuring a just culture approach to dealing with critical incidents. A system-wide investment resulting in adequate resourcing to enable less restrictive treatment options for service users via primary care could reduce the current reliance on involuntary psychiatric treatment. Clinicians operating in resource constrained services that are dominated by prevailing risk averse and paternalistic culture will be challenged to reorientate service provision to support less restrictive treatment options without a fundamental transformation in the broader socio-political context.

Ethical statements

Ethical approval was obtained from Metro South Hospital and Health Service Human Research Ethics Committee (HREC/2022/QMS/81909) and Griffith University Human Research Ethics Committee (GU Reference No: 2022/548). Written informed consent was obtained from each individual prior to participation.

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CRediT authorship contribution statement

Kimbali Wild: Writing – review & editing, Formal analysis, Data curation. **Jappan Sawhney:** Writing – original draft. **Marianne Wyder:** Writing – review & editing, Methodology, Formal analysis, Data curation. **Bernadette Sebar:** Writing – review & editing, Supervision, Data curation. **Neeraj Gill:** Writing – review & editing, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors have no conflicts of interest to declare with respect to the research, authorship and/or publication of this article.

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