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Submission:

Canberra Health Services Clinical Procedure Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015

Submitted by email to:
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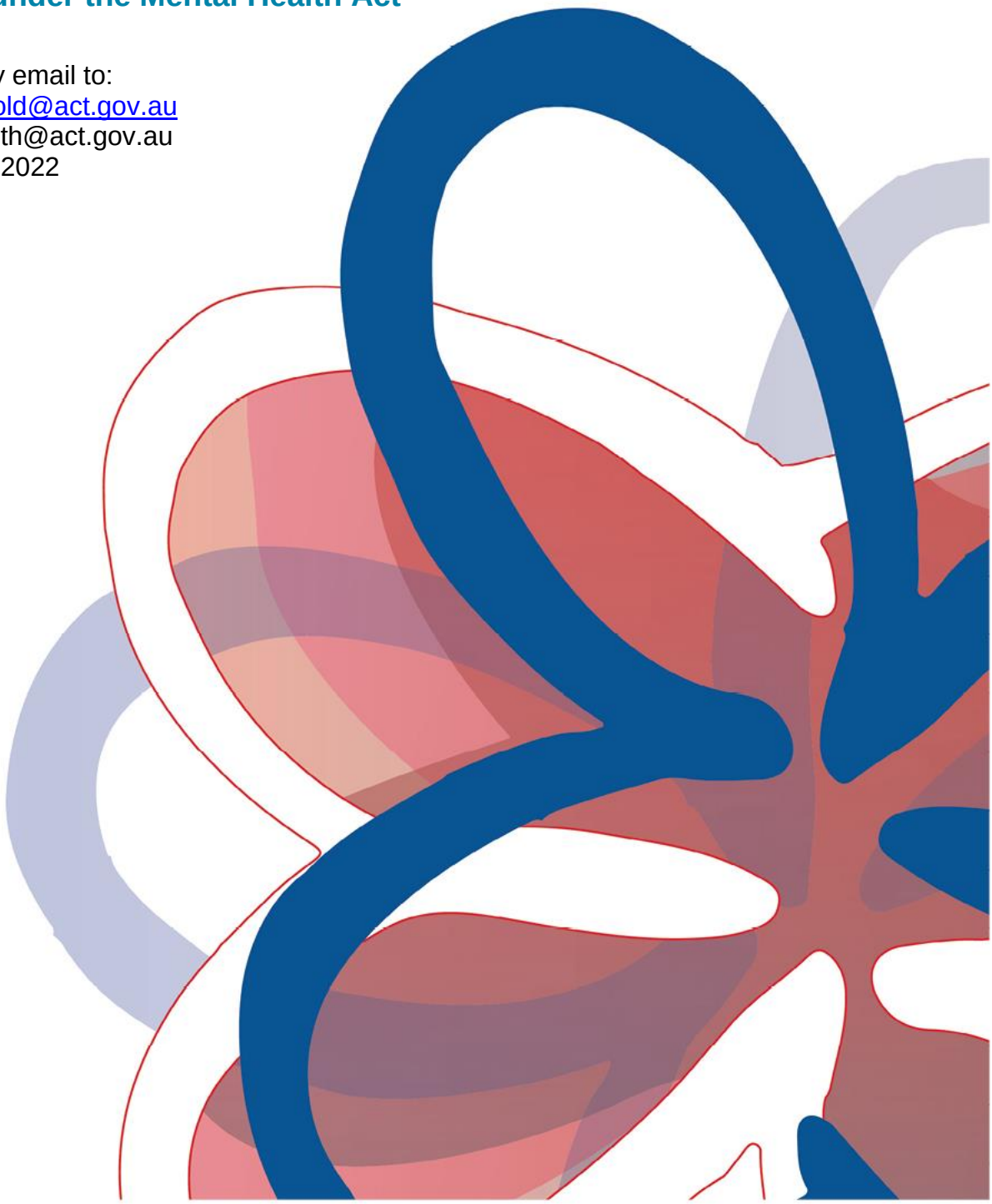

Submission: Canberra Health Services Clinical Procedure Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015

This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from Jacqui Clissold, Senior Policy Officer, Strategy and Governance, Canberra Health Services.

The Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

A consumer e-Forum was held and additional feedback was sought via email in relation to the Canberra Health Services (CHS) Clinical Procedure Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015. Written and verbal feedback was received from several consumers. This submission incorporates both the written feedback and verbal feedback received.

General comments

The Network welcomes this opportunity to contribute to the CHS Clinical Procedure Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015.

Consumers do not sanction seclusion

Consumers clearly stated that their provision of comments and recommendations regarding this procedure in no way sanctions or legitimises the use of seclusion in Mental Health inpatient units. Consumers referenced research around the trauma caused by seclusion and the limited efficacy it has to keep people safe as a therapeutic technique.

Consumers draw your attention to the Recommendation 54, in the Final Report of the Royal Commission into Victoria's Mental Health System[1]. This recommendation

[1] Royal Commission into Victoria's Mental Health System: Final Report, Recommendations, Plain language Version (https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_PlainLanguage_Recommendations.pdf)

identifies the goal of erasing seclusion and restraint in mental health and wellbeing service delivery in 10 years.

While their first recommendation would be to eliminate seclusions, consumers are providing recommendations to this CHS Clinical Procedure recognising that it is included in the *Mental Health Act* (2015) ACT (the Act). In addition, they acknowledge that elimination of seclusions would require changes to the Act which is a longer term project.

Nominated Persons, Advance Consent Directive, Advance Agreements

The wording and the provisions of the Act should be included in this document where appropriate. The Act provides mental health consumers with the ability to complete forms to put in place the following supports for when they become unwell:

- Advance Agreement;
- Advance Consent Direction; and
- Nominated Person.

It is important that these instruments are noted in the procedure in all relevant places and this submission identifies where they should be added.

A consumer's nominated person is a trusted person they have identified should they lack decision making capacity or need assistance regarding their mental health treatment. The Advance Agreement and Advance Consent Direction provide essential information about a consumer's treatment, care and other details of importance. All three of these instruments, if in place, are noted on a consumer's hospital record in case of future need.

As an inpatient, a consumer's Nominated Person is the appropriate person to contact, rather than a listed next of kin who may no longer be current. A consumer's Advance Agreement and Advance Consent Direction provide details as to who can and cannot be contacted when a person presents for hospital care and treatment. They can also outline de-escalation techniques that work for this particular patient reducing the need for any seclusion.

Detained under Mental Health Act 2015

This clinical procedure states, Alerts, p2 that "*only a person on a mental health order under the Mental Health Act 2015 may be secluded.*" Consumers were concerned that they had heard that some consumers who are no longer on an order were being secluded.

Section 3.1 and individual mental health facilities/units

Consumers noted that the information contained p8, Section 3, 3.1 – General Information is sometimes repeated under individual mental health units and is sometimes not. Consumers recommend that for EACH mental health unit the full information re seclusions should be included to ensure that the information is available at a quick glance rather than in reading the whole document.

Use of seclusion for safety of a patient

Consumers are concerned that, at times, the seclusion rooms are used for patients who are feeling unsafe on the general ward from bullying, violence, noise etc. Consumers strongly argued that use of seclusion rooms should not be used for such incidences and the Canberra Hospital inpatient facilities should be trauma informed and as such have areas where consumers can go to remove themselves from the general ward as required.

Collection and use of data

Consumers expressed concern that whilst the data is not available, it is likely that in the same way as incarceration in the ACT, seclusions are likely to be used on specific populations more than others, such as Aboriginal and Torres Strait Islanders. For some cultures, and some trauma survivors, being isolated and locked in a room in solitary can increase their feelings of vulnerability and mental distress.

Public reporting requirements are minimal. While the ACT is consistent on reporting seclusion events, there is very little information available on rolling seclusions, how many four-hour periods in a row the patient is in seclusion for etc.

Canberra Health Services Clinical Procedure Seclusion of Persons with Mental Illness or Mental Disorder Detained under the Mental Health Act 2015

Recommendation 1: Inclusion of a harm statement at beginning of Procedure

Consumers recommend including at the beginning of the CHS Clinical Procedure a statement acknowledging the trauma that seclusion can cause a consumer. A statement similar to the one in Alerts, p7, "*recognising the potential for trauma related to the experience of seclusion"*. This will provide the clinical staff with an upfront reminder and understanding of the ramifications that seclusion can have on the consumer involved.

Recommendation 2: Inclusion of term "de-escalation"

Consumers strongly advised that the term 'de-escalation' should be included in this document from the very beginning, inserted in Alerts, p2, dot point 2: "*when all **de-escalation techniques and** standard methods for keeping the person and/or others*

safe have failed, …".

The document identifies where the different de-escalation rooms and areas are in the various mental health facilities but does not provide any information as to the types of de-escalation techniques that could be used. Consumers recommend the inclusion of a section on de-escalation up front in this document that identifies the various methods that can be used to illustrate what methods for keeping the person and/or others safe.

Recommendation 3: Trauma Informed Care Practices

There is no indication that the principles of Trauma Informed Care Practices influenced the development of the CHS Clinical Procedure for Seclusion.

Recommendation 4: Safewards

Consumers noted that Safewards is not mentioned in this Procedure document despite being actively used in the Adult Mental Health Unit. Consumers recommend references to Safewards and what it entails should be included.

Recommendation 5: Inclusion of word 'maximum'

The word "maximum" needs to be included in p2, dot point 3 – "*a period of seclusion may only be authorised for a **maximum** period of four hours*" as is referred p8, 3.1 During Seclusion – General Information. This reinforces the policy, up front, that seclusions can be less than four hours.

Recommendation 6: inclusion of Nominated Person

As part of the Act, and outlined above in General Comments, a consumer's Nominated Person is a trusted person they have identified should they lack decision making capacity or need assistance regarding their mental health treatment. A consumers Nominated Person, if in place, will be noted on a consumer's hospital record. A consumer's Nominated Person must be included in the list of appropriate persons to contact, including at pp 4, 5, 7 and 10.

Recommendation 7: inclusion of the words "prior to, or"

The words "prior to, or" needs to be included in p2, dot point 5 – "…*clinicians should identify whether a consumer has an Advance Consent Direction, Advance Agreement and/or Nominated Person as soon as they are admitted and must be considered **prior to, or** during*" a seclusion episode. Waiting until the patient is secluded is too late, as de-escalation techniques that work for the individual patient could be included, possibly removing the need for any seclusion to occur.

Recommendation 8: consistency re advising nominated person/carer/guardian

Consumers noted that for the Paediatric Unit (Adolescent Ward, Centenary Hospital for Women and Children) there is the provision on p7, dot point 2 - "*Where appropriate and if consent is given, people who are directly involved in a person's treatment and care must also be informed as soon as practicable of the seclusion episode*". Consumers recommend that this provision be in place for all the inpatient units pages 3 -6, with consumers Nominated Persons or support person being the ideal person to advise. It is important that Nominated Persons and support persons are advised of a seclusion as soon as practicable so that they can provide the patient with the required support as well as understand what has happened to the consumer.

Recommendation 9: consistency in the use of de-escalation techniques while in secure-de-escalation room

Consumers noted that for Paediatric Unit –Adolescent Ward, Centenary Hospital for Women and Children there is a provision on p6, dot point 1 - "*While in the secure de-escalation room, further de-escalation techniques should be attempted to manage the situation…".* Consumers recommend that this provision be in place for all the inpatient units pp3 -6, with reference to appropriate de-escalation techniques identified earlier in this policy.

Recommendation 10: consistency in what to do if a patient is asleep

Consumers noted that for the Emergency Department (p.9) and the Paediatric Unit – Adolescent Ward, Centenary Hospital for Women and Children (p.10) the provision that is outlined p8, Section 3 – During Seclusion, dot point 2 "*If a person is still or asleep the nursing observations must note respirations*" is repeated. Consumers recommend If it is necessary to be repeated for these two units/departments, then it should be repeated for all units/departments, pages 3-6.

Recommendation 11: consistency in what do if any concern for the patient

Consumers noted that for the Emergency Department (p.9) and the Paediatric Unit – Adolescent Ward, Centenary Hospital for Women and Children (p.10) and there is a provision where "*Any concerns for the person's health should be immediately notified to…"* with the document going on to specify who should be contacted such as the Person in Charge and responsible Doctor. Consumers concluded that if it is necessary for these two units/departments, then it should be included for all units/departments, pages 3-6.

Recommendation 12: remove seclusions association with occupational violence

On page 2, the Occupational Violence Policy and Procedure policy is referred to as a policy to be read in conjunction with this Policy. Consumers are concerned that by framing seclusion as a form of occupational violence it primes staff to think that in order to have a 'safe' work environment, you have to seclude people.

This idea that mental health patients pose an occupational threat is also reinforced, in the statement that "*At least three staff members trained in approved Occupational Violence techniques must be available to attend a person when the seclusion room is opened for any reason. Additional staff may be required if there are safety concerns.*" in Section 2, p7, dot point 4, Section 3: 3.3 Mental Health Short Stay Unit (MHSSU) dot point 5, 3.4 Adult Mental Health Unit and Ward 12b, dot point 3 and 3.5 Dhulwa Mental Health Services (DMHU), dot point 3.

Consumers insist that the procedure should include staff having to have trained in Trauma Informed Care Practices, Safewards, have lived experience or any other form of consumer focussed training to assist consumers coming out of seclusion. In addition, consumers stated their concern that the document does not specify at this point of the document that at least one of the three staff members need to be of the same gender as the consumer under seclusion as stipulated in Section 2, 2.1, dot points 5 and 6. Consumers also saw this as a minimum standard.

Recommendation 13: follow up/debriefing post seclusion

If, after all de-escalation techniques have been tried, a period of seclusion is required, consumers emphasised that follow up/debriefing of the patient as soon as practical post seclusion is essential. A patient may not be able to comprehend follow up on the first request and consumers recommend that patients need to be given time to participate in a follow up/debriefing especially if the patient has received medication that may have a sedative effect.

Consumers were also concerned that, historically, a patient will be required to speak to the assigned nurse about what happened, and the nurse writes down what they think the patient said based on the 5 W's (when, where, who, what, and why). The patient may feel embarrassed and/or angry after seclusion and may not wish to speak with the nurse involved in their seclusion. Consumers recommend that the patient be allowed to determine which member of staff they wish to discuss their seclusion with.

The patient does not get to review this document. Consumers recommend that a process of patient review needs to be introduced to ensure their perspective of incidences pre, during and post seclusion are recorded. This information should also be referred to on the consumers record as it will assist with determining the cause of

the seclusion and, thereby, an indication of when de-escalating techniques could be put in place in the future.

Recommendation 14: Inclusion of Clinical Ethics Review of Seclusions

Consumers were concerned that staff members reviewing another staff members decision to seclude a consumer (p11, 4.1 General Information) based on their clinical and occupational safety perspective, as is currently done by the Restraint, Seclusion, Restrictive Practices Review Committee (RSRPRC), means that it is more than likely to be found to be the correct decision and doesn't take into consideration any trauma informed perspective.

Consumers recommend that once a quarter the 5 Ws notes from the patient debriefing along with the staff review should be considered by a Clinical Ethics committee. Seclusion is a special type of 'therapeutic treatment' and ethical considerations need to be considered.

Recommendation 15: Inclusion of decision trees

The document is confusing as there are different requirements for each clinical area as well as a whole lot of requirements that should be the same no matter where the consumer is being secluded. Consumers recommend that decision trees be used in terms of who can make the decision to place someone into seclusion, what happens when someone is in seclusion, what needs to happen to take someone out of seclusion, who needs to be advised that the person was in seclusion etc. This would increase clarity and reduce the number of errors as staff move around the various mental health areas of Canberra Health Services.

Recommendation 16: Role of the Public Advocate

There is no mention of the Public Advocate in this procedure and consumers recommend that the document should include reference to the Public Advocate and what they can do in this space. This is particularly important as the Public Advocate is made aware of all patients that are under mental health orders.

Recommendation 17: Inclusion of other Mental Health Services

Consumers stated that the other Inpatient Mental Health Services provided in Canberra funded through Canberra Health Services, such as the Older Persons Mental Health Unit and Unit 12N, both provided by Calvary, should be included if seclusion is undertaken in these facilities. Particular consideration was given to the Older Persons Mental Health Unit where patient distress could lead to periods of seclusion.

The following edits are recommended:

- While consumers appreciate this procedure may be written as an internal procedure document, they emphasise that it should ideally be written in plain language to ensure ease of understanding for all staff.
- Substitute Paediatrics for Paediatric Adolescent Ward throughout document (pp. 3 and 8).
- Consistency of using patient or person (Mental Health Act uses patient).
- Removal of, “together with nursing staff” as nursing staff have already been included in the sentence (p8, Section 3.1, dot point 7).

Conclusion

These recommendations are based on consumer feedback provided to improve the document from a consumer’s perspective, with particular feedback on trauma informed care and the inclusion of de-escalation techniques.